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Men And Therapy: Comparisons Of College Men Who Have Sought Therapy And Have Not Sought Therapy

Robert L. Reis II

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by

Robert L. Reis II
Bachelor of Arts, University of Minnesota-Twin Cities, 2001
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A Dissertation

submitted to the Graduate Faculty

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in partial fulfillment of the requirements

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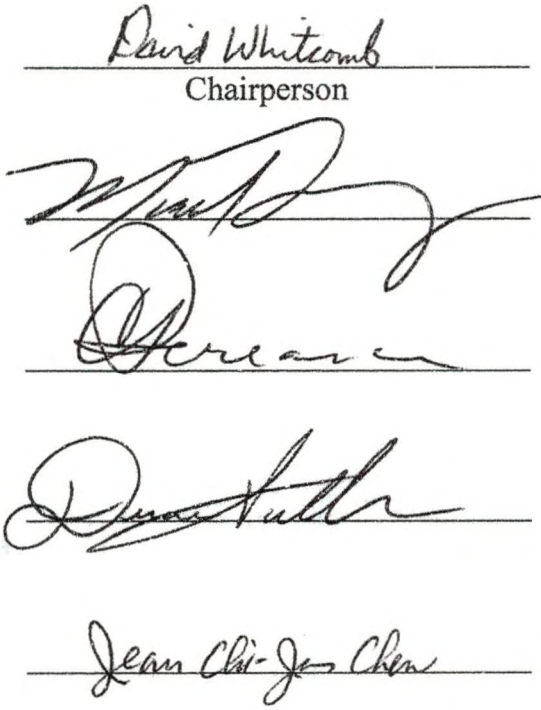
This dissertation, submitted by Robert L. Reis II in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.



David Whitcomb
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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

Joseph M. Benoit
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Date 6-28-07

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ACKNOWLEDGMENTS

I would first like to thank my friends and family for supporting me during my graduate school experience and through my health difficulties. Their love, support, and humor helped me make it through one of the more stressful experiences of my life. Mom, dad, and Travis have been a strong support through all of my educational experiences. I would like to especially thank my friends Kari and Nick and my classmates Kendra, Allison, Cheryl, and Grace. Also, I have been lucky to work with the greatest internship cohort I could ask for. Mary, Mary, and Pam have all been instrumental in helping me make the final push on my dissertation and have been great friends.

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ABSTRACT

For at least the past couple of decades, men have utilized help-seeking services less than women. Sex-difference research demonstrates that men and women utilize help-seeking at different rates; men use it less often. Gender-role socialization research demonstrates that gender role conflict plays a role in keeping men from attending therapy. None of the research compares men who are in therapy with men who have never been in therapy. The purpose of this study is to demonstrate the similarities and differences between men who have sought therapy and those who have not sought therapy.

The main hypothesis is that gender role conflict, loneliness, depression, attitudes towards help seeking, and psychological symptoms will all be significant variables in predicting membership into the group of men who have sought therapy and those who have not sought therapy. The following secondary hypotheses are also examined in the current study. In comparison to men not in therapy: (a) Men in therapy will have lower scores on gender role conflict (as measured by GRCS), (b) Men in therapy will have higher depression scores (as measured by CES-D) , (c) Men in therapy will have more favorable attitudes toward seeking professional psychological help (as measured by ASPPH), (d) Men in therapy will have higher levels of symptom distress (as measured by the HSC), (e) Men in therapy will be more lonely (as measured by the UCLA), and (f) that collapsed across both therapy and non-therapy groups, the following variables will all be significantly related to attitudes towards seeking psychological help and some of

these variables will account for unique variance in attitudes towards help seeking: gender role conflict, depression, symptoms endorsed, and loneliness.

The sample included 44 men who had sought therapy and 44 men who had not sought therapy. All of the men completed the instruments via an internet survey. The results indicated that group membership could be significantly predicted. The results indicated that loneliness and attitudes towards help-seeking were the only two predictors that significantly contributed to the model. Results from secondary hypotheses indicated that men who had sought therapy had higher levels of depression, loneliness, psychological symptoms, and more positive attitudes about seeking professional psychological help. The results also indicated that men who had sought therapy did not differ on their levels of gender role conflict when compared to men who had not sought therapy. It was also found that as gender role conflict increased, attitudes towards seeking help decreased. The results are further discussed and clinical and research implications are explored. Future research should continue to use men who have sought therapy, to more clearly understand what leads men to seek help.

CHAPTER I

INTRODUCTION

Mental health concerns affect both men and women, but men continually use helping services and therapy at a lower rate than women (D'Arcy & Schmitz, 1979, Rule & Gandy, 1994). D'Arcy and Schmitz (1979) found that women use substantially more health services in regards to psychiatric problems. Rule and Gandy (1994) found that women and girls were consistently more likely to seek counseling and that there was no significant change in the attitude difference between men and women from 1976 to 1989 regarding help seeking. It has also been found that men and women differ in prevalence of certain disorders or symptom groups. For example, Wiseman, Guttfreund, and Lurie (1995) found that men and women in counseling differed on their rates of depression and loneliness (women higher on depression, men higher on loneliness). Oliver, Reed, Katz, and Haugh (1999) found that undergraduate students at a midsize Midwestern university used counselors (professional counselors and school counselors) at a different rate by gender. The researchers found that both men and women are more likely to talk to informal helpers (e.g., family, friends, and teacher) than formal helpers and that women are more likely to talk to both formal and informal sources of help than men are. Men used counselors 12.2% of the time when they need help and women used counselors at a rate of 15.7%, although this difference was not statistically significant.

Many studies have been conducted that compare men on different variables (e.g., gender role conflict, depression, loneliness, symptomatic distress), but no studies have

compared men in therapy and out of therapy on these variables. Moreover, no study up to this point has used a multivariate logistic regression to determine if these variables in combination can predict group membership of men in therapy and not in therapy.

The purpose of the current study is to compare men in therapy (or past therapy experience) with men who are not or never have been in therapy. Comparisons are made on attitudes towards help seeking, depression scores, symptom checklists, personality characteristics, gender role, and demographic variables.

One of the first steps in finding a way to get men to come to therapy is to find out what differs and what is similar between men in and out of therapy. Men's difficulty in initiating therapy has been documented for more than two decades (Blazina & Watkins, 1996; Chamow, 1978; Good & Wood, 1995). Chamow (1978) found that men come to therapy in three ways: (a) for their own specific problems that have culminated in a recent event, (b) because they have been requested to by someone else, and (c) because they have been in marital counseling, have separated or divorced, and chose to stay for individual therapy. Reading Chamow's article today provides a historical perspective on men and help seeking. It is interesting to note that many of the same perceptions discussed in 1978 continue to be noted in the literature today.

There has been much research on the role of gender roles on men's attitudes towards help seeking (Blazina & Watkins, 1996; Good & Wood, 1995). Gender roles are behaviors that are enacted congruently with the socially constructed ideas of masculinity and femininity. Gender role socialization paradigms assume that men and women learn gendered attitudes and behaviors from social environments. In these social environments cultural values, norms, and ideologies about what it means to be men and women are

reinforced and modeled (Englar-Carlson, 2006). Eisler (1995) described three inferences regarding men's gender role development. The first inference is that men learn to evaluate their adequacy on the basis of their ability to adjust their behavior in accord with their learned masculinity gender schema. The second inference is that this process is developmental, but that it becomes stable at an early age. The last inference is that some men become more rigid or committed to this adherence to society's masculine schemas as a determination of their worth. It is also important to note that gender roles may vary based on sexual orientation, geographic region, race/ethnicity, age, religion, and socioeconomic status. For this reason, many researchers have begun to discuss masculinities, rather than one single masculinity (Englar-Carlson, 2006).

Gender Role Conflict is defined as a, "psychological state where gender roles have negative consequences or impact on a person or others" (O'Neil, Helms, Gable, David, & Wrightsman, 1986, p. 336). Blazina and Watkins (1996) found that men who scored higher on the Gender Role Conflict Scale (GRCS) view seeking help more negatively than men who scored lower on the GRCS. Good and Wood (1995) examined the role of restriction-related and achievement-related male gender role conflict on depression and help-seeking attitudes. Restriction-related gender role conflict reflects a limiting of both male friendships and emotional expressiveness, and can also be defined as things that "real men" are supposed to feel or do (Good & Wood). They found that restriction-related male gender role conflict accounted for 25% of the variance in help-seeking attitudes and achievement-related male gender role conflict was unrelated to help-seeking attitudes. The limitation of these studies is that they were done solely on

groups of men from a non-clinical sample. A non-clinical sample may differ from a clinical sample on levels of depression.

A unique aspect of the current study is to make comparisons between a clinical sample (have sought therapy) and a non-clinical sample (never sought therapy). Although there is much research regarding the influence of gender role conflict on men's help seeking attitudes, most of the research has solely focused on a non-clinical sample. This study will examine characteristics of men who seek therapy and those that do not. It is anticipated that this study will provide vital information about the similarities and differences between these two groups of men. This information can be used by therapists in their efforts to facilitate men coming to therapy and by future researchers in their efforts to find interventions or strategies that will result in men who need therapy being more likely to seek therapy. Addis and Mahalik (2003) stated, "Men's relative reluctance to seek help stands in stark contrast to the range and severity of the problems that affect them" (p. 6). Some of the provided examples include the fact that men die on average 7 years before women and have higher rates of the 15 leading causes of death. The goal of this study is to greater understand how men decide to seek help and from this information introduce interventions that can increase men's help seeking attitudes. Men's mental health has direct links to their physical health, and the goal is to provide new answers to what facilitates men's help-seeking. Masculinity and gender roles may be an influential factor on why or why not a man is in therapy, but can also affect how therapy is conducted (Englar-Carlson, 2006). Working with men provides special challenges that are often contrary to how therapists were trained. Male clients may be noted as difficult or resistant, as many men may dismiss the value of disclosure or provide limited

emotional expression (Stevens & Englar-Carlson, 2006). This study hopes to contribute to the understanding of what contributes to men deciding to seek therapy, which should help future research to continue to examine how men behave in therapy.

CHAPTER II

LITERATURE REVIEW

The literature in the area of men's help seeking attitudes is generally done via two different methods: (a) sex difference research and (b) gender role conflict research. The literature review therefore falls into these two categories. The gender role conflict research section also contains subsections on theory, intervention, and career counseling.

Men's help seeking attitudes and behavior have been studied continuously for the past two decades. This literature review examines sex difference research, male health needs assessments, gender role conflict and help seeking, and interventions tested to help lessen the underutilization of psychological services of men.

Male Help-Seeking Attitudes and Behaviors

Chamow (1978) stated that men come to therapy in the three following ways: (a) for their own specific problems that have culminated in a recent event; (b) because they have been requested to by someone else; (c) because they have been in marital counseling, become separated or divorced, and then chose to stay for individual therapy. A limitation of his study is that it is based on the author's experience as a therapist, rather than a scientifically gathered sample. Although the statements are solely retrospective observation, it is interesting to note that many of the same perceptions regarding men and therapy from 1978 may still be affecting and influencing men today.

Addis and Mahalik (2003) reviewed the body of research regarding men and help seeking behaviors. The authors split most of the research into two paradigms: sex

difference research and gender role conflict research. Addis and Mahalik stated that limitations of sex difference research include the following: (a) fails to provide an explanation of the difference between men and women in help-seeking patterns, (b) does not address within-group or within-person variability, and (c) can be used to support gender constraining stereotypes of women and men. Role socialization research follows the assumption that men and women learn gendered attitudes and behavior from cultural value and norms about what it means to be a man or a woman. Gender role socialization research examines the degree to which men have adopted gender roles (Addis & Mahalik). The authors stated that gender-role socialization research is an advancement from sex-difference research, but still has limitations, which includes the difficulty in explaining how men can differ in behavior in different situations. The gender-role socialization research does not provide a way "to account for why some men, under some conditions, will seek help for some problems but not for others" (Addis & Mahalik, p. 8).

Sex Difference Research

Sex difference research focuses on examining the differences between men and women. These differences are examined in terms of help-seeking, prevalence of disorders, and many other factors. The following review of sex difference research will focus on sex differences in attitudes towards therapy.

Rule and Gandy (1994) compared results from a single survey conducted in 1976 and replicated in 1989. The authors looked at five different areas: (a) characteristics differentiating those who seek and do not seek counseling, (b) preference for types of helpers, (c) types of client problems, (d) responsibilities of the professional helper, and (e) attitude toward theoretical orientation of the professional. The authors found that

women were consistently more likely to seek counseling, and that this did not significantly change from 1976 to 1989. Also, there were no significant changes in the responsibility of outcome during this period. The responsibility of outcome suggests how much responsibility the client places on the therapist to produce change or be more active in therapy. A limitation of the study is that the data are from only one university, decreasing the generalizability of the sample.

D'Arcy and Schmitz (1979) used an existing data file on all persons in Saskatchewan, Canada who received medical treatment over two years for an explicitly psychiatric disorder. The authors found that women were substantially higher users of health services for psychiatric problems and that sex was the best predictor of utilization. The authors also stated that location (urban vs. rural) did not seem to have an effect on the utilization of services, in that women used twice as many services as men in both urban and rural areas. Limitations of the study are that (a) the data is based on a 1971 dataset, (b) there were no data regarding the availability of services in rural versus urban settings.

Wiseman, Guttfreund, and Lurie (1995) stated that often people who are depressed also are lonelier than those that are not depressed, although loneliness and depression are distinct concepts. The authors hypothesized: (a) that there would be a gender difference in loneliness, with male counseling-seekers obtaining higher loneliness scores than female counseling-seekers; (b) that there would be a gender difference in depression, with female counseling-seekers obtaining higher depression scores that male counselin seekers; (c) that there would be a positive relationship between loneliness and depression for both males and females; and (d) that there would be an interaction effect

of level of depression severity by gender. The authors came to the hypothesis that there would be gender differences based on past research, which has demonstrated that men often have higher loneliness scores on the UCLA.Loneliness Scale.

Wiseman et al. (1995) administered a Personal Information Questionnaire, The UCLA Loneliness Scale short form, and the Beck Depression Inventory to a clinical sample of 325 university students seeking counseling at the university counseling center (107 men, 218 women). Confirming their hypotheses, the authors found that male counseling-seekers obtained higher loneliness scores and women obtained higher rates of depression. They also found a significant correlation ($r = 0.36$) between depression and loneliness. The two-way interaction of depression severity and gender was not significant. Wiseman, Guttfreund, and Lurie explained the gender differences in loneliness and depression in two different ways: (a) the differential patterns of loneliness and depression represents a real difference between men and women counseling-seekers and (b) gender differences in response set (gender role socialization leads women seeking counseling to express their distress by admitting to symptoms of depression, whereas it leads men seeking counseling to express their distress by admitting to social isolation). Limitations of the study are that it used a correlational design, meaning that the results can be interpreted in a variety of different ways, and that the researchers did not seem to control for the initial diagnosis of the clients.

Barry, Doherty, Hope, Sixsmith, and Kelleher (2000) conducted a study examining the perception of mental health (more specifically suicide and depression) issues among rural communities in Ireland. The purpose of the study was to inform the development of appropriate interventions and to provide pre-prevention data to measure

the success of the intervention studies. The study used a quasi-experimental design targeting four rural communities across Ireland. Both questionnaires and vignette focus groups were used to measure the perception of mental health. The authors found that, in comparison to women, (a) men were significantly less concerned about current levels of suicidality, depression, and access to service; (b) men feel uncomfortable and lack confidence about how best to deal with depression and suicide and what advice to give to other people dealing with psychological issues; (c) men were less likely to confide in family members about emotional problems; and (d) men had less positive attitudes about consulting professional help. One limitation of the study is that it may not be generalizable to the United States, due to its Irish sample. Also, a mixed quantitative and qualitative design was used, but unfortunately the lack of rigor of the qualitative methodology makes the results less reliable.

Davies et al. (2000) conducted seven 75-minute focus groups at the University of Oregon focusing on college men's health concerns, barriers to seeking healthcare, and recommendations to help college men adopt healthier lifestyles. Forty-nine male students participated in the focus groups. The focus groups consisted of 2 fraternity groups, 1 residence hall group, 1 group from recreational classes, 1 group from the Gay, Lesbian, Bisexual, and Transgender (GLBT) Center, and 1 group from the multicultural center. The authors asked the men what health issues they are most concerned about, what actions they take to address their health needs, what would motivate them to adopt a more healthy lifestyle, what keeps men from reaching their goals, and how the university could provide better and more services for men. The authors found that men's socialization to conceal vulnerability and be independent was viewed as the greatest barrier to visiting

health services and that seeking counseling services carried a greater social stigma than seeking medical service. Also, a motivational barrier was found for men who do not recognize that long-term health risks are associated with current habits. Men are more likely to be involved in risk-taking activities that are dangerous to themselves and others, more likely to drink alcohol, more likely to have risky sexual behavior, and more likely to drive dangerously. The motivational barrier makes it less likely for college men to realize the long-term consequences of current behavior. The authors speculated that they would have difficulty recruiting participants, and that the participants that did show up would not be open in the discussion of health issues. Contrary to the prediction of the authors, they actually found that focus groups of men discussing health issues were productive. Limitations discussed by the authors include limited generalizability, as participants were all University of Oregon students. Additional limitations were limited discussion of the qualitative method and how the data were analyzed and that some of the data may not be transcribed perfectly due to the malfunction of the audio equipment. An interesting link to the current study is that seeking counseling service was found to carry more stigma than seeking medical service. In this study, it is hoped that by comparing men in therapy and men that have not been in therapy it will be possible to determine what qualities, disorders, or types of distress relate to men going to therapy.

In summary, sex difference research has demonstrated that men and women differ in various aspects of help-seeking, presenting problems, and barriers to help seeking. Specifically, men seek professional help at a lower rate than women. A major limitation of the sex difference research discussed thus far is that it provides no explanation for why the differences between genders exist or why men do not utilize therapy at higher rates.

The research simply demonstrates the differences in a correlational design. The next step in the research is to determine what keeps men from attending therapy. Gender-role socialization research examines gender role conflict and its influence on attitudes towards help-seeking. This is one attempt to find a reason that men use therapy at lower rates than women.

Male Help-Seeking Behavior

Timlin-Scalera, Ponterotto, Blumberg, and Jackson (2003) conducted a grounded theory study of help seeking behaviors among White male high school students. Although the present study uses college students, the proximity of ages of college students to high school students makes many of these findings relevant to the present study. The sample used in this study included 35 interviewees (22 White males, 4 female students, 5 guidance counselors, and 4 parents). The results indicated that males in this community (conservative, traditional, wealthy community) faced much pressure to fit in and be successful in all areas of their life. Also, while working towards these goals it was required that the men maintain strong and "manly" independent images. Many of the male adolescents felt they could not seek help if they have problems; gay males, athletes, and males with learning disabilities had other unique challenges, although it is unclear how many participants in their sample fit these categories. Of the males that did seek help, most often informal resources were sought. Findings indicated that barriers to seeking formal help services included a lack of awareness of resources, lack of insight into their problems, concerns about confidentiality, unfamiliarity with mental health professionals, not wanting to burden others, and a stigma about male weakness being associated with seeking help for problems.

Gender Role Socialization Research

Gender-role socialization research has been conducted to determine its applicability to understanding the underutilization of psychological services by men. Paramount to gender role socialization research is the assumption that men and women learn gendered attitudes and behaviors from cultural values, norms, and ideologies about what it means to be men or women (Addis & Mahalik, 2003). This research has demonstrated the relationship between traditional male roles and men's reluctance to attend counseling. Gender-role socialization research has also been used to examine career counseling, substance abuse counseling, and interventions that attempt to make men more likely to come to therapy (Ritter & Cole, 1992; Blazina & Watkins, 1996; Rochlen & O'Brien, 2002).

Good, Dell, and Mintz (1989) conducted a study to test the theory that help-seeking behavior of men is related to adherence to traditional male gender roles. The authors used 401 undergraduate male students who completed the following self-report measures: Attitudes Toward Men Scale, Gender Role Conflict Scale-I (GRCS), Attitudes Toward Seeking Professional Psychological Help Scale (ASPPH), and the Help-Seeking Attitudes and Behaviors Scale. The data were analyzed using a canonical analysis to examine the relationship between the male role variables and help-seeking variables; three separate multiple regressions were used as follow-up. The authors found that traditional attitudes about the male role, concern about expressing emotion, and concern about expressing affection toward other men were significantly related to negative attitudes about seeking psychological help. Interestingly, the authors also found that the success, power and competition subscale of the GRCS-I did not predict the help-seeking

behavior of men. This is contrary to previous literature (O'Neil, 1981) that suggests a link between traditional male gender roles that support power, success, and competition would be contrary to the help-seeking (Good, Dell, & Mintz). The authors found that restricted emotionality significantly predicted decreased past help-seeking behavior and decreased likelihood of future help seeking behavior. Limitations of the study include the lack of generalizability to men outside of college and a primarily Caucasian sample (91.5%). The authors state that therapeutic interventions for traditional men may need to be catered to them, as they may be uncomfortable with the traditional therapy structure and its focus on emotions and feelings.

Berger, Levant, McMillan, Kelleher, and Sellers (2005) examined the impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help seeking. The authors found that attitudes towards seeking professional psychological help are more closely related to traditional masculinity ideology than to gender role conflict. The results also found that there was no significant relationship between alexithymia (difficulty experiencing, fantasizing, thinking about, and expressing one's emotions) and attitudes towards help seeking. The results also suggested that older men have more positive attitudes than younger men toward seeking professional psychological help. The authors stated that this supports past research that has found that older men endorse traditional masculinity ideology less frequently. The authors conclude by stating that increasing men's help seeking may require increasing accessibility and visibility of psychologists in the community.

Gender role research has also been examined cross culturally. Turkum (2005) examined the differences in attitudes of Turkish university students towards seeking

psychological help. Participants included 279 female and 119 male Turkish students. Results indicated that positive attitudes towards help-seeking were significantly higher in female students than male students. There were also significant differences observed among students with different gender roles in terms of attitudes towards help seeking. Using the Bem Sex Role Inventory to label the students as masculine, feminine, androgynous, and undefined, it was found that androgynous students' attitudes were more positive than those of both masculine and undefined students, and the attitudes of feminine students were more positive than those of masculine and undefined students. The last finding was that participants who had experienced psychological treatment had more favorable attitudes than people who had not been in therapy.

Gender Role Conflict and Psychological Issues

Good and Wood (1995) used latent variable modeling to examine whether male college students with greater male gender role conflict (MGRC) suffer from the unfortunate fate of being simultaneously more likely to be depressed and less likely to seek counseling services (double jeopardy). The authors used the GRCS, the Center for Epidemiological Studies Depression Scale (CES-D), and the Attitudes Toward Seeking Professional Psychological Help (ATSSP) on 397 male college students. Male gender role conflict was found to be best modeled as two latent variables: restriction-related MGRC and achievement-related MGRC. Restriction-related MGRC refers to a limiting both of male friendships and of emotional expressiveness, a component reflecting things that "real men" are not supposed to feel or do. Achievement-related MGRC refers to a drive for achievement or what "real men" do. The authors found that restriction-related MGRC accounted for approximately one fourth of the variance in help-seeking attitudes

but was unrelated to men's experience of depression. Also, achievement-related MGRC accounted for approximately one fifth of the variance in depression but was unrelated to help-seeking attitudes. This study demonstrated that the relationship between MGRC, depression, and help-seeking is more complex than has been posited in previous studies, and that achievement-related MGRC differs from restriction-related MGRC. Authors state that limitations of their study are the following: sample consisted of male college students of primarily White, middle-class background, data used in the study are cross-sectional, and the conclusions regarding the constructs of MGRC, depression, and help-seeking attitudes are restricted to the variables that were used to operationalize the constructs of this study. Further limitations of the study are that although they account for 25% of the variance in male help seeking attitudes, they do not have an answer for the other 75%. The current study looks to enhance the extant research by finding other constructs that influence the help-seeking attitudes of men.

Blazina and Watkins (1996) hypothesized that men who scored higher on the GRCS would report higher levels of depression, anxiety, anger, substance usage, and view seeking help more negatively. This study used 148 male undergraduate students to complete the GRCS, Beck Depression Inventory, State-Trait Anger Expression Inventory, State-Trait Anxiety Inventory, Substance Abuse Subtle Screening Inventory (Face Valid Alcohol subscale), and Attitudes Toward Seeking Professional Psychological Help (ATSSPH). The authors found the following: (a) trait anger (angry reaction type) relates to the success, power, and competition variable of the gender role conflict scale; (b) a significant small positive (r=.17) correlation between the success, power, and competition variable and college men's willingness to admit to increased alcohol usage;

(c) Men who scored higher on the Gender Role Conflict Scale viewed seeking help more negatively than did men who scored lower; and (d) the restricted emotionality variable was a significant predictor of attitudes towards help seeking. Limitations noted by the authors were that the sample needs to be more diverse (only college students were used, thereby limiting the generalizability in terms of age), different measures are needed to measure men's level of substance usage, and that although the results are statistically significant, this does not imply that they are clinically significant.

Shepard (2002) examined the patterns of depressive symptoms among men with high gender role conflict. The author first did a factor analysis of the Beck Depression Inventory and found three factors: (a) negative attitudes, (b) performance difficulties, and (c) physiological symptoms. Negative attitudes included items related to a sense of failure, self-dislike, guilt, and pessimism. Performance difficulties included symptoms related to fatigue, work difficulty, irritability, and indecisiveness. Physiological symptoms included items related to weight loss, loss of appetite, and insomnia. Participants in this study completed the Gender-Role Conflict Scale and the Beck Depression Inventory, and included 127 college students. The findings of the study indicate that for college-age men, a connection may exist between Restrictive Emotionality (a subscale of the Gender Role Conflict Scale) and a pattern of depressive symptoms characterized by a negative state of mind, more specifically self-dislike, feelings of failure, guilt, and pessimism. This finding provides support for past studies that have found that Restrictive Emotionality is the strongest gender role conflict predictor of psychological distress for men in both clinical and non-clinical samples. High Restrictive Emotionality suggests a lack of human contact and exchange of

emotions with others, and Shepard suggests that this isolation may contribute to a negative mind.

Simonsen, Blazina, and Watkins (2000) examined the relationship between gender role conflict and psychological well being of gay men. The sample included 117 gay men who completed the *Gender Role Conflict Scale* and the *Hopkins Symptom Checklist*. The authors made two hypotheses: (1) that GRC would be positively correlated with anger, anxiety, and depression and (2) that GRC would be negatively correlated with attitude toward seeking professional psychological help. The results suggested that less anger, anxiety, and depression, and a more favorable attitude toward seeking psychological help was present for gay men where less conflict exists about sharing emotions and expressing affection. Also, the results suggested that for gay men, when more conflicts exist about success, power, and competition, as well as work and family issues, there is more anger, anxiety, and depression. The authors note that sharing affectionate behavior among men emerged as a significant variable in the psychological well-being of the gay men. The authors also noted that there are many similarities between gay and non-gay men, and that few conclusions should be made based on this study when comparing gay men and non-gay men.

Gender role conflict has also been discussed and examined with other psychological constructs. Schwartz, Waldo, and Higgins (2004) examined the relationship between attachment styles and gender role conflict in college men. One hundred seventy male undergraduate students completed the Gender Role Conflict Scale and the Relationship Questionnaire. The results demonstrated that men with secure attachment styles had significantly less gender role conflict with Restrictive Emotionality

in comparison to men with preoccupied, dismissive, or fearful attachment. The authors noted in their discussion of the results that "gender role conflict that is based in the fear of appearing feminine may cause men to have difficulty expressing emotions and to become overly focused on success, achievement, and control over others" (Schwartz, Waldo, & Higgins, p. 145).

Thompkins and Rando (2003) looked at the relationship between gender role conflict and shame in college men. The authors hypothesized that a positive relationship will exist between shame and gender role conflict and that the four factors of gender role conflict will be predictive of shame. The sample included 343 male college students. The results indicated that the Restrictive Emotionality subscale and the Conflict between Work and Family Relationships subscale accounted for a statistically significant variance in shame of participants. These results mean that when men experience gender role conflict around the expression of emotion or the balance of family and work/school, they are likely to experience higher levels of shame.

Mahalik, Locke, Theodore, Cournoyer, and Lloyd (2001) compared men's gender role conflict and its relationship to social intimacy and self esteem in a sample that included people from Australia and the United States. The authors hypothesized that men's nationality and age group would affect the level of gender role conflict and the strength of the relationship between gender role conflict and self-esteem and social intimacy. The participants included a sample from the U.S. and Australia, and a middle-aged and college-aged sample from each respective country. The results indicated that the main effects of age and nationality were not interpretable, as there were significant interactions between these groups and the relationships of gender role conflict to social

intimacy and self-esteem. The results indicated that support of Restrictive Emotionality was influenced by age, as middle-aged men paid a significantly higher cost in terms of their social intimacy when endorsing restrictive emotionality compared to college-aged men. Results indicated that nationality of the participant influences how gender role conflict relates to self-esteem.

Lane and Addis (2005) examined the relationship between male gender role conflict and willingness to seek help for depression and substance abuse from a variety of helpers in a sample of U.S. and Costa Rican men. The sample included 105 men from two universities (60 men from U.S. and 45 men from Costa Rica). The results suggested that Costa Rican men and men from the U.S. showed no difference on success, power, and competition or restricted emotionality. Men from Costa Rica had more gender role conflict regarding affectionate behavior between men and less conflict on the relationship between family and work. The authors found no difference on help-seeking behaviors for men based on whether they were seeking help for depression or substance abuse. The results indicated that men, especially U.S. men, had difficulty talking about depression with their male friends. Restricted emotionality was linked to less likely help-seeking behavior among U.S. men for a variety of helpers, although this was not consistent with the Costa Rican men. Results of this study suggest that men's help seeking behavior is more complex than previous research suggests. It seems that culture and type of helper play a significant role in men seeking help.

Gender Roles and Additional Types of Counseling

Gender roles have been examined in their relation to various types of counseling. In this subsection, studies examining the relationship between gender roles and substance

abuse counseling and gender roles and career counseling will be examined. Ritter and Cole (1992) presented a theoretical paper which aims to explore critical issues related to men within the context of substance abuse help seeking. The authors stated that the majority of clients presenting for substance abuse treatment are men, which is atypical in the health professions (in that women comprise the majority of clients presenting for treatment of most health conditions). According to the authors, help-seeking is incongruent with the male's socialization pattern and this presents men with a psychological conflict. The conflict is that the men are seeking changes in their life, but the therapy environment is antithetical to making these changes. Also, the authors stated that it has been noted that the key aspects of male socialization have a direct effect on men's emotional and psychological functioning. Men in treatment for substance abuse typically come from families of origin that included violence and substance abuse problems (Ritter & Cole). Ritter and Cole suggested that work with men dealing with substance abuse must recognize male gender roles, understand how the men function within society to create and maintain the gender role conflict, and view the man seeking help within this context. Ideas for therapy include men's awareness groups, family interventions, and individual counseling. Also, the authors state that humanistic approaches can work towards resocializing men in the expression of emotion. This article provides theoretical assumptions that provide interesting implications for future studies.

Rochlen and O'Brien (2002a) examined men's reasons for and against seeking career counseling. Participants for the study included 77 men who were recruited to participate in a study titled "Personality Plus" (an ambiguous title was used so more men would participate). All of the men were asked to reflect on their current career situation

and write down three reasons they would seek career counseling and three reasons they would not. The authors used a coding strategy that employed the use of two auditors, and eventually condensed the data into 13 "would" categories and 12 "would not" categories. The most common reasons noted for seeking career counseling included receiving direct advice, general career assistance, help with job placement, and to increase career options. The most common reasons noted for not seeking career counseling included inconvenience, preferences for solving problems without assistance from others, a lack of need, and doubts about the utility of career counseling. An interesting finding is that men did not report that a desire to work through personal issues that might influence the career development process as a reason for seeking career counseling.

The authors suggest the following to improve men's utility of career counseling: (a) career counselors should explore alternative and more convenient methods of providing career services, and (b) researchers and practitioners should work together to provide accurate information regarding the effectiveness of career counselors and how to best find a career counselor who matches the needs and preferences of different clients. Limitations of the study include a sample that includes 77 predominantly European American, traditionally aged college students.

In a separate study Rochlen and O'Brien (2002b) hypothesized: (a) that more traditional men who refrain from expressing their emotions, are uncomfortable in the presence of physical and emotional intimacy with other men, and are preoccupied with success, power, and competition would express negative evaluations of career counseling; (b) that level of career decidedness, attitudes toward career counseling, and gender role conflict would predict willingness to participate in a career counseling

session, and (c) that men's gender role conflict would play an important mediating role in men's evaluations of two types of career counseling. The authors had 301 male undergraduates complete various questionnaires, and watch and read about two different types of career counseling: person-environment fit and psychodynamic-integrative approach.

Contrary to the hypothesis, the authors found that although men may differ in their level of gender role conflict, less variance exists on how men feel about discussing emotions and contextual issues within a career counseling session (men preferred the person-environment career counseling style). Also contrary to hypothesis, it was found that the value that men attributed to career counseling was not related to men's comfort with closeness with other men, restriction in emotions, or preoccupation with success, power, and competition. As hypothesized, men who had more traditional gender role conflict tended to attach higher levels of stigma to career counseling than did less traditional men. Contrary to the authors' hypothesis, preoccupation with success, power, and competition was not associated with high levels of stigma regarding career counseling. Limitations of the study included: (a) videotapes and case vignettes were used to portray counseling sessions, (b) the study looked at two relatively divergent models of career counseling, and (c) generalizations to counselors and clients from diverse cultures cannot be made due to the homogeneity of the clients and counselors.

Marketing Mental Health Services towards Men

Rochlen, Blazina, and Raghunathan (2002) conducted a study examining gender role conflict, attitudes towards career counseling, career decision-making, and perceptions of career counseling advertising brochures. The study included two separate

brochures. The first brochure was a gender-neutral control version that described the career counseling services of a large university counseling center. The second brochure was tailored to men. The study was completed on 123 male undergraduate students. The authors found that both brochures designed for this study resulted in improvements in attitudes toward career counseling, both in the perceived value and stigma associated with the service. These findings suggest that men's attitudes towards career counseling can be changed by educating the men and providing clear descriptions of how career counseling works. Interestingly, the authors found that orienting brochures specifically toward men did not provide any additional benefit over the gender neutral brochure. Another related finding in this study is that high gender role-conflicted men expressed a greater need for occupational information and for self-clarity, and overall more career indecisiveness.

Blazina and Marks (2001) completed a similar study which examined male college students' reactions to one of three treatment brochures: (a) individual therapy, (b) a psychoeducational workshop, or (c) a men's support group. Each college student was asked to rate his willingness to complete the treatment format he read about, his emotional reactions to it, and how powerful he saw the therapist in his or her particular treatment format. The results indicated that highly gender role conflicted men had more negative mood reactions for all three types of therapy. Additionally, gender role conflicted men had more negative reactions to the men's support group. These findings indicate that when counseling men, a men's support group is not the first option that should be offered to highly gender role conflicted men. An interesting finding that is directly related to the study discussed in this paper is the impact of having previous

treatment experience. Gender-role conflicted men who had previously been in treatment showed significantly less negative attitudes towards therapy. Lastly, the results indicated that highly gender-role conflicted men saw the therapist as significantly more powerful than men with moderate or low gender role conflict.

The National Institute of Mental health sponsored a "Real Men, Real Depression" campaign; Rochlen, McKelley, and Pituch (2006) examined the preliminary results. The "Real Men, Real Depression" campaign was the first large-scale initiative with the primary goal of raising public awareness about depression among men. There were some unique contributions of this campaign. First, the RMRD materials were the first publicly available materials that acknowledged that depression may be felt, described, and exhibited differently by men. Secondly, the RMRD materials clearly acknowledge the stigma and difficulty that men face in seeking help. Third, the spokespeople of the campaign come from the peer reference group which represents the values that have been socially defined as critical aspects of the male identity. The study examining the RMRD materials was conducted on 209 male college students. The results of the study were complex, but the interaction effects indicated that men with low gender-role conflict and negative help-seeking attitudes more favorably endorsed the RMRD materials.

Gender Roles and their Implications on other Attitudes and Behaviors

Gender role conflict has also been found to be related to other behaviors and attitudes. The behaviors and attitudes in this subsection include views towards women and African Americans, risky sexual behavior, and condom-related beliefs. Robinson and Schwartz (2004) examined the relationship between gender role conflict and attitudes towards women and African Americans. The participants included 381 undergraduate

students. The authors found that the Gender Role Conflict Scale subscale of Restrictive Affectionate Behavior between Men (RABBM) is the strongest predictor of attitudes toward the rights and roles of women. These results suggest that the inability of men to relate to other men may lead to nonprogressive or traditional roles for women in society. The results also found that RABBM and the Success, Power, and Competition subscale were the strongest predictors of attitudes toward African Americans. The authors stated that White American men who had difficulty relating to other men had more negative attitudes of African Americans. These cumulative results provide evidence that gender role conflict does not just impact the men, but other people associated with these men.

Sherer, Hosterman, Gillen, and Lefkowitz (2005) sought to describe college students' gender role attitudes and to examine the associations between these attitudes and risky sexual behavior and condom-related beliefs. The study found that masculinity ideology was a far better predictor of risky sexual behavior than were gender-based attitudes toward family roles. Beliefs that men should not express stereotypically feminine quality behaviors increased the likelihood that the men have had unprotected sex in their lifetime. A belief in the importance of high status for men was more common among men who have not had unprotected sex and who used a condom at the last sexual encounter, contrary to what the authors predicted. This data demonstrates that gender roles influence the sexual behavior of young adults, although not always in the predicted direction.

Changing Gender Role and Help-Seeking Attitudes

Brooks-Harris, Heesacker, and Mejia-Millan (1996) conducted a study that measured the effect of two different interventions on changing male gender-role attitudes.

One intervention focused on creating less traditional male gender-role attitudes and the other intervention focused on enhancing participants' attitudes toward seeking psychological help. The authors hypothesized that participants in the traditional male role attitude change group would have significantly lower scores on the Brannon Masculinity Scale and the GRCS-I than those in the control group, thus indicating the effectiveness of an elaboration likelihood model (ELM) based intervention in changing men's traditional gender-role attitudes. ELM is an empirically supported method of attitude change and this study focused on using a central route of attitude change because the attitudes are likely to have a more lasting change (Petty & Cacioppo, 1986).

College undergraduate men (142) were divided into three groups (two treatment, one control). The first treatment groups saw video vignettes focusing on changing traditional male gender-role attitudes. The second treatment group saw video vignettes focusing on enhancing participants' attitudes toward seeking psychological help. Results demonstrated that the video vignettes were successful in altering the male participants' general attitudes (in regards to other men) about the traditional male role, but were not successful in altering men's personal gender role attitudes or resolving gender role conflicts. Also, an unexpected finding demonstrated that the help-seeking video vignettes did not successfully alter participants' help-seeking attitudes, but it did result in a change in their male role attitudes. The results indicated that men who were exposed to an intervention had significantly less traditional attitudes towards masculinity on the Brannon Masculinity Scale. The fact that men did change on their male role attitudes suggest that it may be easier to change men's general and impersonal attitudes about masculinity than to change their more specific and self relevant gender-role attitudes and

behaviors (as measured by the GRCS-I). Limitations of the study include that it is solely a college sample and the absence of longitudinal data regarding the effectiveness of the intervention in long-term attitude changes.

Mahalik, Good, and Englar-Carlson (2003) looked at the roles of masculinity and made theoretical suggestions on ways in which men's gendered lives can be incorporated into therapeutic work with men. The authors provided masculinity scripts which allow clinicians to make connections between how masculinity may be connected to the issues that men present when coming to counseling and therapy. The authors discussed the following male scripts that are present in and out of therapy: tough-guy script, give-'em hell script, playboy script, homophobic script, winner script, and independent script. The authors suggested that when working with men, first determine what the salient masculinity scripts are for a particular client; second, identify the positive functions these scripts serve; and third, comprehensively document their costs. The authors also discuss how these scripts can influence psychological help seeking.

Implications of the Mahalik et al. (2003) study for training include the following: (a) psychologists must be knowledgeable about masculine socialization, (b) psychologists should strive to recognize the interface between an individual's experiences of masculine socialization and his thoughts, behaviors , and feelings regarding getting help, (c) gender role analysis should be incorporated into psychologists' work with men, and (d) psychologists should become aware of and continually review their own values and biases and the effects these have on their male clients. This article provided interesting ways to conceptualize male clients and use this conceptualization to provide men with comfortable therapy. In order to use this information more effectively, it would be

necessary for the authors to operationalize the scripts, possibly provide an instrument to classify male clients, and provide therapy suggestions based on the male script. This study was a good first step and relied on the notion that counseling should be catered to fit the client, but more research on the scripts and their relationship to therapy needs to be done.

Summary

The first section of the literature review focused on sex difference research, which provided us with a demonstration that men are using mental health services at a lower rate than women. The second section of the literature review took this one step further and looked at possible influences in male help seeking, more specifically, the effects of gender role conflict. Gender role conflict research has demonstrated that traditional gender roles play an important role in males' attitudes towards help-seeking. Research has demonstrated the role of gender roles on seeking help for traditional counseling, substance abuse counseling, and career counseling. Also, suggestions for overcoming the powerful messages of gender roles and their impact on help-seeking behavior have been suggested. The gender role socialization research provides just a small piece of the answer, often accounting for only a small portion of the variance in help-seeking behaviors. Another criticism of the literature is that the research is not done on men who are in therapy. One perhaps obvious point that tends to be overlooked in the literature is that although men use therapy less frequently, there are still many men that do use therapy. It is important to look at the two groups of men and see if they differ on gender role conflict, as well as other variables including depression, anxiety, symptoms endorsed, and loneliness.

Current Study

The literature discussed above demonstrates that men have and continue to use psychological services to a lesser extent than women. It has also been demonstrated that gender role conflict plays a role in keeping men from initiating individual counseling, substance abuse counseling, and career counseling. This information leads to the current study.

The purpose of the current study is to compare men who are in therapy (or have been in therapy) with men who have never been in therapy. From the above literature review, it is evident that there is no study that looks at both men in and out of therapy. By comparing the two groups of men, it is hoped that more concrete similarities and differences between the groups of men can be determined. These findings may help therapists create an environment where men feel comfortable initiating counseling. The main hypothesis is that gender role conflict, loneliness, depression, attitudes towards help seeking, and psychological symptoms will all be significant predictors of two categories of group membership: men who have sought therapy and men who have not sought therapy. The following secondary hypotheses are also examined in the current study: (a) Men in therapy will have lower scores on gender role conflict (as measured by GRCS) than men not in therapy, (b) Men in therapy will have higher depression scores (as measured by CES-D) than men not in therapy, (c) Men in therapy will have more favorable attitudes toward seeking professional psychological help (as measured by ASPPH) than men not in therapy, (d) Men in therapy will have higher levels of symptom distress (measured by the HSC) than men not in therapy, (e) Men in therapy will be more lonely (as measured by the UCLA) than men not in therapy, and (f) that collapsed across

both therapy and non-therapy groups, gender role conflict, depression, symptoms endorsed, and loneliness will all be significantly related to attitudes towards seeking psychological help and some of these variables will account for unique variance in attitudes towards help seeking. The primary hypothesis is multivariate, taking all predictors into account and testing whether or not group membership can be determined from the predictors. The secondary hypotheses are the univariate hypotheses that look at each predictor individually and determine if there is a difference between the therapy group and the non-therapy group of men.

CHAPTER III

METHODS

Participants

Due to the various hypotheses of the present study, the study was comprised of all men. The sample consisted of 158 men. The clinical sample included 44 men who have sought therapy and 114 men who have not sought therapy. The men in the clinical sample were recruited from university counseling centers. The non-clinical sample was recruited from three Midwestern universities. The ethnicity of the participants was as follows: 86.7% Caucasian/White, 1.9% Black/African-American, 1.9% Hispanic/Latino, 5.1% Asian-American/Pacific Islander, 1.9% Biracial/Multiracial, and 2.5% missing. The mean age for the sample was 24.18 years and range from 18-48. Participants described their self income as follows: 79.7% under $20,000, 12.0% $20,000-$40,000, 3.8% $40,001-$60,000, 0.6% $60,001-$80,000, 1.9% $80,001-$100,000, and 1.9% over $100,000. Participants described their parental income as follows: 10.8% under $20,000, 16.5% $20,000-$40,000, 22.2% $40,001-$60,000, 17.7% $60,001-$80,000, 11.4% $80,001-$100,000, and 21.5% over $100,000. The sample was also asked to report their current relationship status. The sample described their relationship status as follows: 50.6% single, 25.3% dating, 20.3% partnered, 1.9% divorced, and 1.9% missing. The educational level of the participants was reported as follows: 10.1% first-year student, 17.1% sophomore, 13.3% junior, 30.4% senior, 13.9% master's student, 5.1% doctoral student, 3.8% professional student, and 6.3% other.

The clinical sample included 44 participants and the non-clinical sample included 114 participants. A random sample of these 114 non-clinical participants was selected, using a random number generator, to obtain 44 participants who had not sought counseling. This was done to create equal group sizes between the clinical sample and the non-clinical sample. In the results and discussion chapters, the analyses conducted using this random sample will be identified as the abridged sample. A data analysis of the non-clinical group that is contained in the abridged sample and the unused non-clinical sample was conducted to ensure that the abridged sample is indeed a representative sampling of the larger non-clinical sample. A statistical analysis described in the results section indicated that the abridged non-clinical sample can be assumed to be a representative sample of the larger non-clinical group.

Demographics for the smaller sample (88 participants) are described in the following paragraph. Forty-four of the participants had sought therapy and 44 of the participants have not sought therapy. The ethnicity of the participants was as follows: 85.2% Caucasian/White, 1.1% Black/African-American, 3.4% Hispanic/Latino, 3.4% Asian-American/Pacific Islander, 3.4% Biracial/Multiracial, and 3.4% missing. The mean age for the sample was 24.74 years and range from 18-48. Participants described their self income as follows: 77.3% under $20,000, 13.6% $20,000-$40,000, 5.7% $40,001-$60,000, 2.3% $80,001-$100,000, and 1.1% over $100,000. Participants described their parental income as follows: 5.7% under $20,000, 15.9% $20,000-$40,000, 23.9% $40,001-$60,000, 13.6% $60,001-$80,000, 15.9% $80,001-$100,000, and 25.0% over $100,000. The sample described their relationship status as follows: 58.0% single, 20.5% dating, 18.2% partnered, and 3.4% divorced. The educational level of the participants

was reported as follows: 8.0% first-year student, 19.3% sophomore, 13.6% junior, 31.8% senior, 11.4% master's student, 5.7% doctoral student, 2.3% professional student, and 8.0% other.

Demographics for the clinical sample (44 participants) are described in the following paragraph. The ethnicity of the clinical sample was as follows: 84.1% Caucasian/White, 4.5% Hispanic/Latino, 4.5% Asian-American/Pacific Islander, 2.3% Biracial/Multiracial, and 4.5% missing. The mean age for the clinical sample was 27.23 years and range from 18-48. Clinical sample participants described their self income as follows: 70.5% under $20,000, 13.6% $20,000-$40,000, 11.4% $40,001-$60,000, and 4.5% $80,001-$100,000. Participants described their parental income as follows: 9.1% under $20,000, 15.9% $20,000-$40,000, 27.3% $40,001-$60,000, 9.1% $60,001-$80,000, 13.6% $80,001-$100,000, and 25.0% over $100,000. The sample described their relationship status as follows: 54.5% single, 11.4% dating, 27.3% partnered, and 6.8% divorced. The educational level of the participants was reported as follows: 2.3% first-year student, 15.9% sophomore, 13.6% junior, 25.0% senior, 22.7% master's student, 6.8% doctoral student, 4.5% professional student, and 9.1% other.

Demographics for the non-clinical sample (44 participants) are described in the following paragraph. The ethnicity of the non-clinical sample was as follows: 86.4% Caucasian/White, 2,3% Black/African-American, 2.3% Hispanic/Latino, 2.3% Asian-American/Pacific Islander, 4.5% Biracial/Multiracial, and 2.3% missing. The mean age for the non-clinical sample was 22.25 years and range from 18-40. Participants described their self income as follows: 84.1% under $20,000, 13.6% $20,000-$40,000, and 2.1% over $100,000. Participants described their parental income as follows: 2.3% under

$20,000, 15.9% $20,000-$40,000, 20.5% $40,001-$60,000, 18.2% $60,001-$80,000, 18.2% $80,001-$100,000, and 25.0% over $100,000. The sample described their relationship status as follows: 61.4% single, 29.5% dating, and 9.1% partnered. The educational level of the participants was reported as follows: 13.6% first-year student, 22.7% sophomore, 13.6% junior, 38.6% senior, 4.5% doctoral student, and 6.8% other.

The clinical sample participants were also asked information about the type of counseling sought and the duration of the counseling. Out of the 44 participants who have sought counseling, 19 indicated that they are currently in counseling and 25 indicated that they are not currently in counseling. Thirty-eight of the participants indicated that they had been in counseling in the past and 6 of the participants indicated that they had not sought counseling in the past, just this current episode. The participants were also asked to estimate the number of sessions they had sought in their lifetime. The results indicated that 2.3% had sought 1 session, 6.8% 2 sessions, 20.5% 3-5 sessions, 6.8% 6-12 sessions, 50% 13 or more sessions, and 13.6% missing. The sample also included 15.9% of participants who had received inpatient hospital treatment, 70.5% who had not received inpatient hospital treatment, and 13.6% who did not answer.

Instruments

Gender Role Conflict Scale (GRCS; O'Neil, Helms, Gable, David & Wrightsman, 1986). The GRCS (See Appendix A) consists of 37 statements designed to assess men's thoughts and feelings about their gender role behaviors. Men report their agreement or disagreement with each statement on a Likert-like scale of 1 (strongly disagree) to 6 (strongly agree). The GRCS measures masculine role stress in terms of four factors or subscales: (a) success, power, and competition; (b) restricted emotionality; (c) restricted

affectionate behavior between men; and (d) conflict between work and family relations. The success, power, and competition subscale (GRCS-SPC) describes personal attitudes about success derived through competition and power. The restricted emotionality subscale (GRCS-ResEmo) is described as having difficulty finding words to describe emotions and having difficulty and fear expressing one's emotions. The restricted affectionate behavior between men subscale and homophobia subscale (GRCS-Homo) is described as having difficulty describing one's feelings or thoughts to other men and difficulty touching other men. The family relations subscale (GRCS-FR) measures the difficulty between balancing work-school with family responsibilities. The GRCS also has a total score. The higher the score on the subscale or the total score, the higher the level of gender role conflict. Good and Mintz (1990) found the Cronbach's alpha to be .89 for the whole scale, .86 for the success, power and competition subscale, .84 for the restrictive emotionality subscale, .88 for the restricted affectionate behavior between men subscale, and .78 for the conflict between work and family relations subscale. Discriminant validity was found between the GRCS and the CES-D, with a modest but statistically significant correlation of .26 (Good & Mintz).

Center for Epidemiological Studies-Depression Scale (CES-D: Radloff, 1977). The CES-D (See Appendix B) is a 20-item self-report scale designed to measure depressive symptomatology. Each of the items is rated on a scale from zero to three depending on the frequency of symptom occurrence. For each item, a higher score indicates a higher degree of depressive symptoms (Items 4, 8, 12, and 16 are reverse scored). The sum of all twenty items lead to a total score ranging from 0-60. The internal consistency of the CES-D describes four factors: depressive affect, somatic symptoms,

interpersonal relations, and positive affect. The α coefficient was found to be α = .85 for the general population and α = .90 for a psychiatric population.

Attitudes Toward Seeking Professional Psychological Help (ASPPH; Fisher & Turner, 1970). Participants indicate agreement or disagreement with statements about seeking help for psychological problems. The ASPPH (See Appendix C) consists of 29 items that use a Likert-like scale of 0 to 3. The scores range from 0 to 87. Higher scores denote more positive attitudes towards help-seeking. For this study, the word *psychologist* was substituted for *psychiatrist* (as was done in Blazina & Watkins, 1996). The internal consistency was found to be .86 (Fischer & Turner, 1970). The test-retest reliability for two months was found to be $r = .84$. Fischer and Turner also provided evidence of construct validity. The authors found that both men and women that had sought therapy in the past had more favorable attitudes towards help seeking than men and women who had not sought previous help.

The ASPPH is also broken into four subscales: (a) recognition of need, (b) stigma tolerance, (c) interpersonal openness, and (d) confidence in mental health practitioners. The recognition of need subscale (ASPPH-Recog) indicates a recognition of personal need for psychotherapeutic support. The stigma tolerance subscale (ASPPH-ST) assesses the participants' opinions about the threat of stigmatization as a result of receiving mental health treatment. The interpersonal openness subscale (ASPPH-Interper) measures the participant's self-reported interpersonal openness or willingness to reveal troubles to an appropriate professional. The final subscale, confidences in mental health practitioners (ASPPH-Con), describes faith in psychotherapy techniques and beliefs that mental health

practitioners are confident. As with the overall score, higher scores on the subscales indicate more positive attitudes towards help-seeking. (Fischer & Turner, 1970)

UCLA Loneliness Scale (UCLA: Russell, 1996). The UCLA (See Appendix D) is a twenty-item measurement of loneliness. The participants determine if this occurs often (O), sometimes (S), rarely (R), or never (N). Higher scores indicate higher degrees of loneliness. Coefficient alphas range from .89 to .94 and test-retest reliability over a 1-year period was $r = .73$. Convergent validity for the scale was indicated by significant correlations to other measures of loneliness, including the NYU Loneliness Scale and the Differential Loneliness Scale (Russell, 1996).

Hopkins Symptom Checklist (HSC; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The HSC (See Appendix E) is a 58-item measure of psychological symptoms. The participants determine how much discomfort that problem has caused them during the past week, including today. The participant rates the distress on the following scale: 0 is "not at all distressed", 1 is "a little distressed", 2 is "quite a bit distressed", and 3 is "extremely distressed". Higher scores indicate higher distress.

The HSC is divided into five subscales: (a) somatization, (b) obsessive-compulsive, (c) interpersonal sensitivity, (d) depression, and (e) anxiety. The somatization subscale (HSC-Som) reflects distress arising from perceptions of bodily dysfunction. The somatization subscale has an internal consistency value of $\alpha = .87$ and a test-retest reliability of $r = .82$. The obsessive-compulsive subscale (HSC-OC) reflects symptoms that are closely related to obsessive-compulsive disorder. The obsessive-compulsive subscale has an internal consistency value of $\alpha = .87$ and a test-retest reliability of $r = .84$. The interpersonal sensitivity subscale (HSC-Interper) focuses on

feeling of personal inadequacy and inferiority, particularly when comparing oneself to others. The interpersonal sensitivity subscale has an internal consistency value of α =.85 and a test-retest reliability of r = .80. The depression subscale (HSC-Dep) represents symptoms related to clinical depression. The depression subscale has an internal consistency value of α =.86 and a test-retest reliability of r = .81. The anxiety subscale (HSC-Anx) reflects symptoms of anxiety including restlessness, nervousness, and tension. The anxiety subscale has an internal consistency value of α =.84 and a test-retest reliability of r = .75. (Derogatis et al., 1974).

Demographics Form. The demographic form (See Appendix F) was also included and collected the following data: age, race/ethnicity, personal and parental income information, and therapy attendance. The therapy question was multifaceted. The first question asked if the man was currently in therapy. If he answered yes, he was asked to select a type of therapy (family counseling, group counseling, individual counseling, career counseling, substance abuse counseling, couples counseling), setting of therapy (hospital, community mental health center, private outpatient clinic, university counseling center, other), and the number of sessions in the current treatment. There also was a question regarding if participants have been in therapy in the past. This question also assessed the type of therapy, setting of therapy, number of sessions, and also the age they were at the time of therapy, and the duration of therapy.

Design and Analysis

This study was a between-groups quasi-experimental design. The participants' data were placed into the clinical group or the non-clinical group depending on if they have sought or have not sought therapy. There was no random assignment of participants.

To test the main hypothesis, binary logistic regression was used to determine the probability of predicting group membership. The predictors included the GRCS, CES-D, HSC, UCLA, and ASPPH. These predictors were used to predict whether or not the men attend therapy.

To test the secondary hypotheses, the clinical group scores on the GRCS, CES-D, ASPPH, HSC, and UCLA and their respective subscales were compared with the non-clinical group scores on the same instruments. Simple t-tests were conducted to demonstrate significant mean differences between the clinical sample and the non-clinical sample. After all of the instruments and their subscales were compared between clinical sample and non-clinical sample, a stepwise multiple regression was conducted. This statistic was collapsed over groups and used GRCS, CES-D, HSC, and UCLA as independent variables that contribute to the ASPPH. This statistic can also determine which of these scales individually contribute to the variance in the attitudes towards help-seeking (ASPPH).

Procedure

The experiment was conducted via two different, yet similar methods. The clinical sample was recruited from local university counseling centers. The participating counseling centers included the University of North Dakota Counseling Center, North Dakota State University Counseling and Disability Services, and the University of Missouri-Kansas City Counseling center. Participating clinics asked their male clients if they would be interested in the study. The interested clients were given a recruitment flyer (See Appendix F) that included information about the study and the web address to

complete the survey. Clients were informed that the complete survey would take approximately 30 minutes to complete.

The non-clinical sample was recruited by e-mailing students (See Appendix G) of three Universities. The e-mail addresses were obtained from the Office of the Registrar, or a similar office, and comprised a random sample of all men in the university (500 men per university). The three universities used in the non-clinical sample were parallel to the clinical sample and included the University of North Dakota, North Dakota State University, and the University of Missouri-Kansas City. The e-mail included information about the study and a link to access the online survey. The whole survey took approximately 30 minutes to complete.

Both recruitment methods provided a link to a web survey that was similar for both the clinical sample and the non-clinical sample. All of the participants first read the consent form (See Appendix H) to participate in the study. After the consent form was read the participants were required to electronically sign the consent form by typing their name. This data was separate from any of the questionnaire data, to preserve the confidentiality of the participants. All of the participants were then taken to a second secure webpage to participate in a drawing for fifty dollars. Participants were asked to provide an e-mail address if they would like to participate in a drawing for one of four fifty-dollar cash drawings. As with the consent form data, the e-mail addresses for the lottery were not linked to the consent form data or the data from the questionnaires, to protect the confidentiality of the participants.

After the lottery webpage, the participants were randomly assigned to one of three surveys. The three surveys all included the demographics form, GRCS, CES-D, HSC,

UCLA, and ASPPH. The only difference from the three on-line surveys was the order of the instruments presented to the participants. All three surveys began with the demographics form. Survey 1 had the instruments in the following order: (a) HSC, (b) GRCS, (c) CES-D, (d) UCLA, and (e) ASPPH. Survey 2 had the instruments in the following order: (a) ASPPH, (b) CES-D, (c) GRCS, (d) HSC, and (e) UCLA. Survey 3 had the instruments in the following order: (a) UCLA, (b) CES-D, (c) ASPPH, (d) HSC, and (e) GRCS. After the participants completed the survey they were brought to a final webpage that provided the principal investigator's and advisor's e-mail address for questions (See Appendix I). The final page also included the phone numbers for the following counseling centers: University of North Dakota, North Dakota State University, and University of Missouri-Kansas City.

All of the instruments were coded with a number. They were not separated into clinical and non-clinical groups until after the demographic form was filled out. Although most of the men filling out the surveys at the various counseling centers ultimately ended up in the clinical sample (had been in therapy at some point in their life), the non-clinical sample included a majority of men who had never been to therapy, although some had been in therapy (but perhaps not by their own initiative). A question on the demographic form asked if they had ever sought therapy. If this was answered *yes*, they were moved to the clinical sample.

CHAPTER IV

RESULTS

Abridged Sample

The clinical sample included 44 participants and the non-clinical sample included 114 participants. A random sample of these 114 non-clinical participants was selected, using a random number generator, to obtain 44 participants who had not sought counseling. This was done to create equal group sizes for the clinical sample and the non-clinical sample. In the Results and Discussion chapters, most of the analyses were conducted using this random sample, which will be identified as the abridged sample. A data analysis of the non-clinical group that is contained in the abridged sample and the unused non-clinical sample, however, was conducted to ensure that the abridged sample is indeed a representative sampling of the larger non-clinical sample.

An independent samples t-test was conducted between the two components of the non-clinical group for all of the scales (HSC, UCLA, CES-D, GRCS, and ASPPH) and all of the subscales of these scales (HSC-Som, HSC-OC, HSC-Interper, HSC-Dep, HSC-Anx, GRCS-SPC, GRCS-ResEmo, GRCS-Homo, GRCS-FR, ASPPH-Recog, ASPPH-ST, ASPPH-Interper, and ASPPH-Con). The independent samples t-tests indicated that there were no significant differences between the non-clinical group contained in the abridged sample and the unused non-clinical group (Table 1). These results indicated that the abridged non-clinical sample can be assumed to be a representative sample of the larger non-clinical group.

Table 1. Non-Clinical Group Independent Samples T-tests

	t	*df*	*p*
HSC	1.40	112.00	0.17
UCLA	0.68	112.00	0.50
CES-D	0.32	112.00	0.75
GRCS	-0.03	112.00	0.98
ASPPH	-0.06	112.00	0.96
HSC-Som	0.95	112.00	0.34
HSC-OC	0.96	112.00	0.34
HSC-Interper	0.95	112.00	0.34
HSC-Dep	1.30	112.00	0.20
HSC-Anx	1.05	112.00	0.30
GRCS-SPC	-0.31	112.00	0.76
GRCS-ResEmo	0.76	112.00	0.45
GRCS-Homo	-1.23	112.00	0.22
GRCS-FR	0.80	112.00	0.42
ASPPH-Recog	-0.72	112.00	0.47
ASPPH-ST	1.04	112.00	0.30
ASPPH-Interper	0.82	112.00	0.41
ASPPH-Con#	-0.82	77.79	0.42

= Equal variances not assumed
Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

It is also important to note that the clinical sample and non-clinical sample were selected based on the participants' response to whether or not they had sought therapy. Both the clinical sample and the non-clinical sample included participants who had been required to seek therapy. The clinical sample included 10 participants who had been required to seek therapy and had also sought therapy. The non-clinical sample included 7 participants who were required to seek therapy, but had not independently sought

therapy. The reason that these individuals were included in the non-clinical sample is that the purpose of the study is to examine men's motivation to seek therapy.

Means and Standard Deviations

Table 2 provides the means and standard deviations for the scales and subscales. The means and standard deviations were provided for the clinical sample and the non-clinical abridged sample.

Table 2. Means and Standard Deviations on the Dependent Variables for the Two Groups.

	Clinical		Non-Clinical	
	M	*SD*	*M*	*SD*
HSC	43.02	33.59	23.27	15.91
UCLA	51.34	13.43	40.27	9.98
CES-D	20.57	14.48	11.84	7.15
GRCS	130.93	32.17	130.61	31.75
ASPPH	56.61	17.09	47.36	12.63
HSC-Som	5.95	6.18	3.41	2.76
HSC-OC	7.34	6.22	4.32	3.75
HSC-Interper	6.55	5.08	3.30	2.59
HSC-Dep	10.16	8.40	4.70	4.23
HSC-Anx	3.66	4.23	1.59	2.06
GRCS-SPC	51.00	11.64	50.59	13.67
GRCS-ResEmo	31.95	12.44	33.31	12.08
GRCS-Homo	22.91	9.88	24.59	9.09
GRCS-FR	25.07	7.03	22.11	7.82
ASPPH-Recog	15.89	6.10	10.98	4.84
ASPPH-ST	8.98	3.64	8.68	3.22
ASPPH-Interper	14.02	4.91	13.48	3.90
ASPPH-Con	17.73	5.53	14.23	5.57

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

Many of the scales and subscales have published norms associated with the development of the scale, which will be listed in this paragraph. Russell (1996) stated that the norm for college students had a mean of 40.08 and a standard deviation of 9.50 on the UCLA. The published norms are roughly equivalent to the mean for the non-clinical sample ($M = 40.27$) and lower than the clinical sample ($M = 51.34$). Fischer and Turner (1970) stated that a norm for males that had professional contact on the ASPPH had a mean of 65.8 and a standard deviation of 10.5 and men who had no professional contact had a mean of 56.7 and a standard deviation of 11.0, which were both higher than the means and standard deviations found in this study. Moradi et al. (2000) provided means and standard deviations for the GRCS and its subscales. The mean for the total score was 136.9 with a standard deviation of 27.02, which is roughly equivalent to the mean found for both the clinical and non-clinical sample. The means and standard deviations for the subscales were as follows: GRCS-SPC ($M = 51.57$, $SD = 11.33$), GRCS-ResEmo ($M = 32.23$, $SD = 9.78$), GRCS-Homo ($M = 29.59$, $SD = 8.73$) and GRCS-FR ($M = 23.55$, $SD = 5.98$). These norms were based on a 702 participant sample with a mean age of 22.4 and a range of men from ages 16 to 66. Radloff (1991) found the mean for college students ($n = 214$) to be 15.46 with a standard deviation of 9.67 for the CES-D. This norm is directly between the means found for the non-clinical and clinical group. The Hopkins Symptom Checklist did not provide norms for the subscale scores or total score, but rather provided mean item scores in its development sample.

Preliminary Analyses with Abridged Sample

Preliminary analyses were run on the abridged sample to determine whether the scores on the scales and all of the subscales of these scales differed according to several

demographic variables. The following demographics were tested using one-way ANOVAs: race/ethnicity, educational level, relationship status, estimated parental income, estimated self-income, and current living situation. An independent samples t-test was conducted to examine the relationship between working on or off campus and the scales and subscales. A bivariate correlation was conducted to examine the relationship between the scales and subscales, and the following two variables: (a) age and (b) hours worked per week.

Table 3. Race/Ethnicity One-Way Analyses of Variance.

	df	*F*	*P*
HSC	4, 80	0.54	0.71
UCLA	4, 80	0.11	0.98
CES-D	4, 80	0.79	0.54
GRCS	4, 80	1.21	0.31
ASPPH	4, 80	1.51	0.21
HSC-Som	4, 80	1.10	0.36
HSC-OC	4, 80	1.05	0.39
HSC-Interper	4, 80	0.12	0.97
HSC-Dep	4, 80	0.23	0.92
HSC-Anx	4, 80	0.57	0.69
GRCS-SPC	4, 80	0.65	0.63
GRCS-ResEmo	4, 80	1.30	0.28
GRCS-Homo	4, 80	2.45	0.05
GRCS-FR	4, 80	0.57	0.69
ASPPH-Recog	4, 80	1.96	0.11
ASPPH-ST	4, 80	0.86	0.49
ASPPH-Interper	4, 80	0.73	0.58
ASPPH-Con	4, 80	2.41	0.06

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

Race/ethnicity. One-way analyses of variance (ANOVAs) were conducted to determine whether or not responses on the scales and subscales differed by participant race/ethnicity. The results indicated that there were no significant differences on the scales or subscales based on race/ethnicity. The GRCS-Homo approached significance with a p slightly greater than .05 and the ASPPH-Con approaches significance with a p value of .06. The results from the ANOVAs can be found in Table 3.

Education Level. One-way ANOVAs were conducted to determine whether or not a participant's education level was associated with his response on the scales and subscales. The results indicated that there were no significant differences on the following scales (HSC, UCLA, CES-D, and GRCS) or subscales (HSC-Som, HSC-OC, HSC-Interper, HSC-Dep, HSC-Anx, GRCS-SPC, GRCS-ResEmo, GRCS-Homo, GRCS-FR, ASPPH-Recog, and ASPPH-ST) based on educational level. Results of the ANOVAs can be found in Table 4.

A one-way ANOVA was calculated on participants' educational level and the ASPPH scale. The analysis was significant, $F(7, 80) = 2.195$, $p < .05$. Although there was an overall significant F statistic, there were no significant differences between educational levels when conducting a post-hoc Bonferroni test. Although not a significant difference, men who were doctoral students had the most positive views of seeking psychological help ($M = 62.00$, $SD = 10.12$) and sophomores had the most negative view ($M = 42.35$, $SD = 10.66$). A one-way ANOVA was calculated on participants' educational level and the ASPPH-Interper subscale. The analysis was significant, $F(7, 80) = 2.371$, $p < .05$. Although there was an overall significant F statistic, there were no significant differences between educational levels when conducting a post-hoc Bonferroni test. The

highest degree of interpersonal openness was found among "other" students ($M = 16.80$, $SD = 3.63$) and the lowest degree of interpersonal openness was found among sophomores ($M = 11.41$, $SD = 4.20$). Also, a one-way ANOVA was calculated on participants' educational level and the ASPPH-Con subscale. The analysis was significant, $F(7, 80) = 2.621$, $p < .05$. Although there was an overall significant F statistic, there were no significant differences between educational levels when conducting a post-hoc Bonferroni test. The doctoral students had the most confidence in mental health professionals ($M = 21.00$, $SD = 3.67$) and professional students had the least confidence ($M = 11.00$, $SD = 4.24$), although this difference was not statistically significant.

Relationship Status. One-way ANOVAs were conducted to determine whether or not a participant's relationship status was associated with his response on the scales and subscales. The results indicated that there were no significant differences on the following scales (GRCS and ASPPH) or subscales (HSC-Som, HSC-OC, HSC-Interper, HSC-Anx, GRCS-SPC, GRCS-ResEmo, GRCS-Homo, GRCS-FR, ASPPH-Recog, ASPPH-ST, ASPPH-Interper, and ASPPH-Con) based on relationship status. Results of the ANOVAs can be found in Table 5.

A one-way ANOVA was calculated on participants' relationship status and the HSC scale. The analysis was significant, $F(3, 84) = 6.024$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are divorced ($M = 88.33$, $SD = 16.74$) and each of the other relationship categories: single ($M = 35.59$, $SD = 29.06$), $p < .01$; dating ($M = 22.83$, $SD = 18.80$), $p < .01$; and partnered (M

= 26.63, *SD* = 21.85), $p < .01$. Higher scores on the HSC indicate higher levels of symptomatology.

Table 4. Educational Levels One-Way Analyses of Variance.

	df	*F*	*p*
HSC	7, 80	0.56	0.79
UCLA	7, 80	1.29	0.26
CES-D	7, 80	0.96	0.47
GRCS	7, 80	1.19	0.32
ASPPH*	7, 80	2.20	0.04
HSC-Som	7, 80	0.92	0.50
HSC-OC	7, 80	0.31	0.95
HSC-Interper	7, 80	0.59	0.77
HSC-Dep	7, 80	0.73	0.65
HSC-Anx	7, 80	0.49	0.84
GRCS-SPC	7, 80	1.07	0.39
GRCS-ResEmo	7, 80	1.31	0.26
GRCS-Homo	7, 80	1.69	0.12
GRCS-FR	7, 80	0.07	1.00
ASPPH-Recog	7, 80	1.55	0.16
ASPPH-ST	7, 80	0.74	0.64
ASPPH-Interper*	7, 80	2.37	0.03
ASPPH-Con*	7, 80	2.62	0.02

* = $p < .05$

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

A one-way ANOVA was calculated on participants' relationship status and the HSC-Dep subscale. The analysis was significant, $F(3, 84) = 7.625$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are divorced ($M = 21.67$, $SD = 6.51$) and each of the other relationship categories: single ($M = 8.51$, $SD = 7.24$), $p < .01$; dating ($M = 4.17$, $SD = 4.95$), $p < .01$; and partnered (M

= 5.00, *SD* = 5.02), $p < .01$. Higher scores on the HSC-Dep subscale indicate a higher number of depression symptoms endorsed.

Table 5. Relationship Status One-Way Analyses of Variance.

	df	*F*	*p*
HSC*	3, 84	6.02	0.00
UCLA*	3, 84	4.94	0.00
CES-D*	3, 84	6.78	0.00
GRCS	3, 84	0.48	0.70
ASPPH	3, 84	0.69	0.56
HSC-Som*	3, 84	6.97	0.00
HSC-OC*	3, 84	5.11	0.00
HSC-Interper	3, 84	1.43	0.24
HSC-Dep*	3, 84	7.63	0.00
HSC-Anx	3, 84	2.07	0.11
GRCS-SPC	3, 84	0.02	1.00
GRCS-ResEmo	3, 84	1.61	0.19
GRCS-Homo	3, 84	1.41	0.25
GRCS-FR	3, 84	1.81	0.15
ASPPH-Recog	3, 84	0.15	0.93
ASPPH-ST	3, 84	0.32	0.81
ASPPH-Interper	3, 84	1.17	0.33
ASPPH-Con	3, 84	1.03	0.39

* = $p < .05$

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

A one-way ANOVA was calculated on participants' relationship status and the HSC-Som subscale. The analysis was significant, $F(3, 84) = 6.971$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are divorced ($M = 16.00$, $SD = 6.56$) and each of the other relationship

categories: single ($M = 4.43$, $SD = 4.95$), $p < .01$; dating ($M = 3.33$, $SD = 2.59$), $p < .01$; and partnered ($M = 4.88$, $SD = 4.21$), $p < .01$. Higher scores on the HSC-Som subscale indicate a higher number of somatization symptoms endorsed.

A one-way ANOVA was calculated on participants' relationship status and the HSC-OC subscale. The analysis was significant, $F(3, 84) = 5.110$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are divorced ($M = 15.00$, $SD = 3.00$) and each of the other relationship categories: single ($M = 6.47$, $SD = 5.38$), $p < .01$; dating ($M = 3.89$, $SD = 3.52$), $p < .01$; and partnered ($M = 4.25$, $SD = 5.24$), $p < .01$. Higher scores on the HSC-OC subscale indicate a higher number of obsessive compulsive symptoms endorsed.

A one-way ANOVA was calculated on participants' relationship status and the UCLA Loneliness scale. The analysis was significant, $F(3, 84) = 4.944$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are single ($M = 48.94$, $SD = 13.15$) and dating ($M = 37.06$, $SD = 8.64$), $p < .01$. Higher scores on the UCLA indicate higher levels of loneliness.

Lastly, a one-way ANOVA was calculated on participants' relationship status and the CES-D scale. The analysis was significant, $F(3, 84) = 6.775$, $p < .01$. A Bonferroni post-hoc examination of the results indicated a significant difference between people who are divorced ($M = 39.67$, $SD = 13.05$) and each of the other relationship categories: single ($M = 17.88$, $SD = 12.25$), $p < .01$; dating ($M = 11.83$, $SD = 9.54$), $p < .01$; and partnered ($M = 11.38$, $SD = 8.12$), $p < .01$. Higher scores on the CES-D indicate a higher number of depression symptoms endorsed.

Estimated parental income. One-way ANOVAs were conducted to determine whether or not a participant's estimated parental income was associated with his response on the scales and subscales. The results indicated that there were no significant differences on the scales or subscales based on estimated parental income. The results from the ANOVAs can be found in Table 6.

Table 6. Estimated Parental Income One-Way Analyses of Variance

	df	*F*	*P*
HSC	5, 82	0.06	1.00
UCLA	5, 82	1.50	0.32
CES-D	5, 82	0.29	0.92
GRCS	5, 82	0.46	0.81
ASPPH	5, 82	0.19	0.97
HSC-Som	5, 82	0.50	0.78
HSC-OC	5, 82	0.22	0.95
HSC-Interper	5, 82	0.35	0.88
HSC-Dep	5, 82	0.22	0.95
HSC-Anx	5, 82	0.47	0.80
GRCS-SPC	5, 82	1.43	0.22
GRCS-ResEmo	5, 82	0.47	0.80
GRCS-Homo	5, 82	0.42	0.83
GRCS-FR	5, 82	0.37	0.87
ASPPH-Recog	5, 82	0.46	0.81
ASPPH-ST	5, 82	0.46	0.81
ASPPH-Interper	5, 82	0.19	0.97
ASPPH-Con	5, 82	0.31	0.90

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

Estimated self income. One-way ANOVAs were conducted to determine whether or not a participant's estimated self income was associated with his response on the scales

and subscales. The results indicated that there were no significant differences on the scales or subscales based on estimated self income. The results from the ANOVAs can be found in Table 7.

Table 7. Estimated Self Income One-Way Analyses of Variance.

	df	*F*	*P*
HSC	4, 83	1.27	0.29
UCLA	4, 83	1.32	0.27
CES-D	4, 83	1.26	0.29
GRCS	4, 83	0.71	0.59
ASPPH	4, 83	0.57	0.68
HSC-Som	4, 83	0.32	0.87
HSC-OC	4, 83	1.59	0.18
HSC-Interper	4, 83	0.99	0.42
HSC-Dep	4, 83	1.52	0.20
HSC-Anx	4, 83	0.45	0.77
GRCS-SPC	4, 83	0.46	0.77
GRCS-ResEmo	4, 83	0.79	0.53
GRCS-Homo	4, 83	0.89	0.47
GRCS-FR	4, 83	0.87	0.48
ASPPH-Recog	4, 83	0.22	0.93
ASPPH-ST	4, 83	0.54	0.71
ASPPH-Interper	4, 83	0.87	0.49
ASPPH-Con	4, 83	1.07	0.38

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

Living Situation. One-way analyses of variance were conducted to determine whether or not a participant's living situation was associated with his response on the scales and subscales. The results indicated that there were no significant differences on the following scales (HSC, UCLA, CES-D, and GRCS) or subscales (HSC-Som, HSC-OC, HSC-Interper, HSC-Dep, HSC-Anx, GRCS-SPC, GRCS-ResEmo, GRCS-Homo,

GRCS-FR, ASPPH-Recog, ASPPH-ST, and ASPPH-Con) based on living situation. There were significant results on the ASPPH and the ASPPH-Interper. Results of the ANOVAs can be found in Table 8.

Table 8. Living Situation One-Way Analyses of Variance.

	df	*F*	*P*
HSC	5, 82	0.52	0.76
UCLA	5, 82	0.91	0.48
CES-D	5, 82	1.21	0.31
GRCS	5, 82	0.65	0.66
ASPPH*	5, 82	2.76	0.02
HSC-Som	5, 82	1.07	0.39
HSC-OC	5, 82	0.61	0.69
HSC-Interper	5, 82	1.56	0.18
HSC-Dep	5, 82	1.03	0.41
HSC-Anx	5, 82	0.17	0.97
GRCS-SPC	5, 82	0.94	0.46
GRCS-ResEmo	5, 82	0.47	0.80
GRCS-Homo	5, 82	0.16	0.98
GRCS-FR	5, 82	1.47	0.21
ASPPH-Recog	5, 82	1.95	0.10
ASPPH-ST	5, 82	1.30	0.27
ASPPH-Interper*	5, 82	2.35	0.05
ASPPH-Con	5, 82	2.02	0.09

* = $p < .05$

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

A one-way ANOVA was calculated on participants' living situation and the ASPPH scale. The analysis was significant, $F(5, 82) = 2.758$, $p < .05$. A Bonferroni post-hoc examination of the results indicated a significant difference between men who live in a fraternity home ($M = 27.67$, $SD = 9.29$) and live in other campus housing ($M = 60.75$, $SD = 10.39$), $p < .05$. Higher scores on the ASPPH indicate more favorable attitudes

towards seeking professional psychological help. Also, a one-way ANOVA was calculated on participants' living situation and the ASPPH-Interper subscale. The analysis was significant, F (5, 82) = 2.345, $p < .05$. Although there was an overall significant F statistic, there were no significant differences between living situations when using a post-hoc Bonferroni test. The group with the lowest interpersonal openness was men in fraternity housing ($M = 7.33$, $SD = 3.51$) and the highest interpersonal openness was men in "other" living situations ($M = 16.00$, $SD = 1.41$), although the difference is not significant.

On/off Campus Work. An independent samples t-test was conducted between the participants who worked on campus or off campus for all of the scales (HSC, UCLA, CES-D, GRCS, and ASPPH) and all of the subscales of these scales (HSC-Som, HSC-OC, HSC-Interper, HSC-Dep, HSC-Anx, GRCS-SPC, GRCS-ResEmo, GRCS-Homo, GRCS-FR, ASPPH-Recog, ASPPH-ST, ASPPH-Interper, and ASPPH-Con). The independent samples t-tests indicated that there were no significant differences between the two groups, except on the ASPPH-Recog subscale (Table 9). The results indicated that participants who worked off campus recognized the need for professional help ($M = 12.03$, $SD = 5.27$) less than those who worked on campus ($M = 14.89$, $SD = 5.76$), t (66) $= 2.125$, $p < .05$.

Age. Bivariate correlations were conducted to examine the relationship between age and the scales and subscales. The following results were significant. Results indicated that higher age was associated with lower homophobia (GRCS-Homo), $r = -0.226$, $p < .05$. It was also found that higher age was associated with men who were more likely to recognize the need for professional psychological help (ASPPH-Recog),

r =0.271, p <.05. The higher the participant's reported age, the more likely he was to be interpersonally open (ASPPH-Interper), r =0.310, p <.01. The confidence in mental health professionals (ASPPH-Con) was also higher in participants who indicated higher age, r =0.354, p <.01. Lastly, the overall attitude towards seeking professional psychological help (ASPPH) was significantly more positive as reported age was higher, r = 0.359, p <.01.When solely the undergraduate participant scores were used in the correlation, there were no significant correlations with age.

Table 9. On/Off Campus Work Independent Samples T-tests.

	t	*df*	*p*
HSC	-0.74	66.00	0.46
UCLA	0.58	66.00	0.56
CES-D	0.59	66.00	0.56
GRCS	-0.74	66.00	0.46
ASPPH	1.35	66.00	0.18
HSC-Som	-0.23	66.00	0.82
HSC-OC#	-1.52	65.91	0.13
HSC-Interper#	-1.25	65.57	0.22
HSC-Dep	0.10	66.00	0.92
HSC-Anx	-1.21	66.00	0.23
GRCS-SPC	-0.90	66.00	0.37
GRCS-ResEmo	1.17	66.00	0.25
GRCS-Homo	-1.37	66.00	0.09
GRCS-FR	-1.70	66.00	0.09
ASPPH-Recog*	2.13	66.00	0.04
ASPPH-ST	-0.03	66.00	0.97
ASPPH-Interper	0.05	66.00	0.96
ASPPH-Con	1.47	66.00	0.15

= Equal variances not assumed
* = $p < .05$
Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

Hours of work per week. Bivariate correlations were conducted to examine the relationship between hours of work per week and the scales and subscales. The only significant finding was that as men reported higher hours of work per week, family relations became more conflictual (GRCS-FR), $r = 0.374$, $p < .01$.

Main Analysis

The main hypothesis was that gender role conflict, loneliness, depression, attitudes towards help seeking, and psychological symptoms will all be significant variables in predicting membership into the group of men who have sought therapy and those who have not sought therapy. This hypothesis was tested using a binary logistic regression. The enter method was chosen, as it is theoretically supported that all five predictors will significantly contribute to the model, based on past research.

This hypothesis was partially supported. The logistic regression demonstrated that as all five predictors were entered into the model, the model was significant, χ^2 (5) = 37.621, $p < .01$. The model successfully predicted 46.4% of the variance in group membership, Nagelkerke $R^2 = .464$. The model successfully predicted 77.3% of the clinical group and 84.1% of the non-clinical group, with an overall prediction rate of 80.7%. The Homer and Lemeshow test indicated that $p = .424$, indicating that the model's estimates fit the data at an acceptable level (Grerson, 2006). The only two significant predictors were ASPPH (Wald (1) = 8.335, $p < .01$) and UCLA (Wald (1) = 7.176, $p < .01$). The binary logistic regression results can be found in Table 10.

Secondary Hypotheses

All of the secondary hypotheses were run using the clinical sample and the non-clinical abridged sample. The first secondary hypothesis was that men who have sought

therapy will have lower scores on gender role conflict (as measured by GRCS). An independent samples t-test was conducted for the GRCS and its subscales using the abridged sample. There were no significant differences between men who had sought therapy and those that had not sought therapy (Table 11).

Table 10. Multivariate Logistic Regression Analysis Predicting Group Membership.

	β	Wald	*df*	*p*	Odds Ratio
ASPPH	-0.07	8.34	1	0.004*	0.94
UCLA	-0.09	7.18	1	0.007*	0.91
CES-D			1	0.908	
GRCS			1	0.412	
HSC			1	0.189	

* = $p < .01$
Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help.

The second secondary hypothesis was that men who had sought therapy will have higher depression scores (as measured by CES-D). The results from the independent samples t-test indicated that men who have sought therapy have higher levels of depression ($M = 20.57$, $SD = 14.49$) than men who have not sought therapy ($M = 11.85$, $SD = 7.157$), t (62.799) = 3.584, $p < .01$ (Table 11).

The third secondary hypothesis was that men who had sought therapy will have more favorable attitudes toward seeking professional psychological help (as measured by ASPPH). An independent samples t-test was conducted for the ASPPH and its subscales using the abridged sample. The results indicated non-significant results for the ASPPH-ST subscale and the ASPPH-Interper subscale. In contrast, men who have sought therapy were more likely to recognize the need for therapy (ASPPH-Recog, $M = 15.89$, $SD = 6.10$) than men who have not sought therapy ($M = 10.98$, $SD = 4.84$), t

(81.798) = 4.180, $p < .01$. Also, men who have sought therapy have significantly more confidence in mental health professionals (ASPPH-Con, $M = 17.73$, $SD = 5.53$) than men who have not sought therapy ($M = 14.23$, $SD = 5.57$), t (86) = 2.957, $p < .01$. Lastly, men who have not sought therapy indicated significantly less favorable attitudes toward seeking psychological help (ASPPH, $M = 47.36$, $SD = 12.63$) than men who have sought therapy ($M = 56.61$, $SD = 17.09$), t (86) = 2.887, $p < .01$. Therefore the results for the ASPPH and two of its subscales (ASPPH-Recog and ASPPH-CON) supported the hypothesis. Table 11 includes the t-values for all the subscales.

The fourth secondary hypothesis was that men in therapy would have higher levels of symptom distress (as measured by the HSC). An independent samples t-test was conducted for the HSC and its subscales using the abridged sample. As hypothesized, men who have sought therapy endorse more symptomatology (HSC) ($M = 43.02$, $SD = 33.59$) than men who have not sought therapy ($M = 23.27$, $SD = 15.92$), t (61.383) = 3.525, $p < .01$. The results indicated significant results on the following subscales, with men in therapy endorsing more symptoms: somatization (HSC-Som) (Clinical; $M = 5.96$, $SD = 6.18$) (Non-clinical; $M = 3.41$, $SD = 2.77$), t (59.569) = 2.495, $p < .05$; obsessive compulsive symptoms (HSC-OC) (Clinical; $M = 7.34$, $SD = 6.22$) (Non-clinical; $M = 4.32$, $SD = 3.75$), t (70.568) = 2.761, $p < .01$; interpersonally sensitive (HSC-Interper) (Clinical; $M = 6.55$, $SD = 5.08$) (Non-clinical; $M = 3.30$, $SD = 2.59$), t (63.965) = 3.778, $p < .01$; depression symptoms endorsed (HSC-Dep) (Clinical; $M = 10.16$, $SD = 8.40$) (Non-clinical; $M = 4.71$, $SD = 4.23$), t (63.498) = 3.848, $p < .01$; and anxiety symptoms (HSC-Anx) (Clinical; $M = 3.66$, $SD = 4.23$) (Non-clinical; $M =$

1.59, $SD = 2.06$), t (62.359) = 2.918, $p < .01$. All of the HSC results can be found in Table 11.

Table 11. Secondary Hypotheses Independent Samples T-tests.

	t	df	p
HSC#*	3.53	61.38	0.00
UCLA# *	4.39	79.42	0.00
CES-D#*	3.58	62.80	0.00
GRCS	0.05	86.00	0.96
ASPPH*	2.89	86.00	0.01
HSC-Som#*	2.50	59.57	0.02
HSC-OC#*	2.76	70.57	0.01
HSC-Interper#*	3.78	63.97	0.00
HSC-Dep#*	3.85	63.50	0.00
HSC-Anx#*	2.92	62.36	0.01
GRCS-SPC	0.15	86.00	0.88
GRCS-ResEmo	-0.52	86.00	0.60
GRCS-Homo	-0.83	86.00	0.41
GRCS-FR	1.86	86.00	0.07
ASPPH-Recog#*	4.18	81.80	0.00
ASPPH-ST	0.40	86.00	0.69
ASPPH-Interper	0.58	86.00	0.57
ASPPH-Con*	2.96	86.00	0.00

* = $p < .05$
# = Equal variances not assumed
Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help; HSC-Som = Somatization subscale of the HSC; HSC-OC = Obsessive-Compulsive subscale of the HSC; HSC-Interper = Interpersonal Sensitivity subscale of the HSC; HSC-Dep = Depression subscale of the HSC; HCS-Anx = Anxiety subscale of the HSC; GRCS-SPC = Success, Power, and Competition subscale of the GRCS; GRCS-ResEmo = Restrictive Emotionality subscale of the GRCS; GRCS-Homo = Homophobia subscale of the GRCS; GRCS-FR = Family Relations subscale of the GRCS; ASPPH-Recog = Recognition of Need subscale of the ASPPH; ASPPH-ST = Stigma Tolerance subscale of the ASPPH; ASPPH-Interper = Interpersonal Openness subscale of the ASPPH; ASPPH-Con = Confidence in Mental Health Practitioners subscale of the ASPPH.

The fifth secondary hypothesis was that men in therapy will be lonelier (as measured by the UCLA). The results confirmed this hypothesis. Men who have sought therapy had higher levels of loneliness ($M = 51.34$, $SD = 13.43$) than men who have not sought therapy ($M = 40.27$, $SD = 9.99$), t (79.415) = 4.387, $p < .01$.

The last secondary hypothesis was that, collapsed across both therapy and non-therapy groups, the following variables will all be significantly related to attitudes

towards seeking psychological help and some of these variables will account for unique variance in attitudes towards help seeking: gender role conflict, depression, symptoms endorsed, and loneliness. This analysis was conducted using a multiple regression with the enter method. The results indicated that the model was significant, F (4, 83) = 4.842, $p < .01$. The results indicated that the predictors (HSC, GRCS, CES-D, UCLA) accounted for 18.9% of the variance on the ASPPH (R^2 =.189). The results did not support the hypothesis that all four predictors would significantly contribute to the regression. The only predictor that significantly contributed to the regression was the GRCS, t = -3.897, $p < .01$. The direction of this regression was as expected, indicating that gender role conflict is negatively correlated with attitudes towards seeking professional psychological help and accounts for 14.8% of the variance. The multiple regression results can be found in Table 12.

Table 12. Regression Analysis Predicting ASPPH.

Block of Variables entered	R	R^2	R^2change	F change	P
HSC	.147	.022	.010	1.900	.172
CES-D	.202	.041	.018	1.703	.195
UCLA	.202	.041	.007	.001	.982
GRCS	.435	.189	.150	15.186	.000

Note: HSC = Hopkins Symptom Checklist; UCLA = UCLA Loneliness Scale; CES-D = Center for Epidemiological Studies-Depression Scale; GRCS = Gender Role Conflict Scale; ASPPH = Attitudes Towards Seeking Professional Psychological Help.

Correlations

Bivariate correlations were conducted between the scales and the subscales. These correlations were conducted to determine the relationships between the subscales and the total scores within scales and between scales. The correlations can be found in Table 13.

Table 13. Bivariate Correlations of Scales and Subscales.

	GRCS	CES-D	UCLA	HSC-ASPPH	HSC-Som	HSC OC	HSC-Interper	HSC-Dep	GRCS-Anx	GRCS-SPC	GRCS-ResEm	GRCS-Homo	GRCS-FR	ASPPH-Recog	ASPPH-ST	ASPPH-In	ASPPH-Con
HSC	.39**	.80**	.56**	-.15	.81**	.89**	.86**	.92**	.84**	.24*	.30**	.23*	.45**	.00	-.29**	-.21*	-.06
GRCS	-	.30**	.46**	-.38**	.31**	.40**	.35**	.29**	.32**	.80**	.80**	.76**	.62**	-.17	-.54**	-.45**	-.20
CES-D		-	.71**	-.20	.53**	.63**	.67**	.88**	.63**	.16	.30**	.19	.26*	-.01	-.29**	-.33**	-.11
UCLA			-	-.15	.28**	.51**	.54**	.63**	.43**	.29**	.42**	.25*	.45**	.10	-.33**	-.30**	-.07
ASPPH				-	-.06	-.12	-.16	-.14	-.01	-.20	-.43**	-.28**	-.23*	.86**	.57**	.73**	.91**
HSC-Som					-	.66**	.57**	.60**	.68**	.15	.26*	.20	.41**	.03	-.13	-.15	.00
HSC-OC						-	.78**	.78**	.68**	.28**	.29**	.24*	.45**	-.01	-.28**	-.18	.00
HSC-Interper							-	.78**	.62**	.24*	.28**	.20	.39**	-.02	-.21	-.25*	-.09
HSC-Dep								-	.73**	.19	.24*	.16	.33**	.00	-.28**	-.22*	-.06
HSC-Anx									-	.23*	.17	.28**	.34**	.11	-.26*	-.05	.04
GRCS-SPC										-	.42**	.48**	.44**	-.05	-.42**	-.27*	-.04
GRCS-ResEmo											-	.55**	.35**	-.22*	-.39**	-.51**	-.32**
GRCS-Homo												-	.25*	-.11	-.41**	-.34**	-.14
GRCS-FR													-	-.15	-.41**	-.20	-.07
ASPPH-Recog														-	.26*	.43**	.81**
ASPPH-ST															-	.41**	.37**
ASPPH-Interper																-	.53**

**. Correlation is significant at the 0 01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Comments

All participants were asked an open-ended question regarding what has led them to seek therapy or kept them from seeking therapy. The comments were then coded via the principal investigator. The comments were not coded by a team or checked for inter-rater reliability, but the comments and coding were also analyzed by the dissertation chair. The comments included 95 responses from men who had sought therapy and 46 responses from men who had not sought therapy. The comments from men that had sought therapy were coded into the following categories: personal growth, relationships, symptom relief, stressors, considered counseling, positive perceptions, career counseling, academic concerns, medication, and identity concerns. The comments from men who had not sought therapy were coded into the following categories: no need, barriers, other support, required therapy, never sought, can solve own problems, negative perception, and self care. The barriers category was broken into the following sub-categories: time, money, don't believe in counseling, no referral, laziness, and fear. The negative perception category was broken into the following sub-categories: stigma, privacy, and anti-counselor. Some of the comments were placed into more than one category, therefore the totals do not add up to the total number of comments. Also, some of the participants' comments fell under both categories that described why they sought therapy and those reasons they may not seek therapy (within a single comment). A chart of responses coded in each category and subcategory can be found in Table 14.

Some of the comments from men who had sought therapy included "To get my life moving in a positive direction" (Personal Growth) and "unable to deal with depression" (Symptom Relief). Some of example comments from men who had not

sought therapy included the following: "I haven't felt the need or ever been told I needed therapy" (No Need), "I feel confident that I am able to work things out/handle life situations on my own" (Can Solve Own Problems), "I think what's kept me from seeking any therapy is the social stigma on it" (Negative Perception) and "It is too gay for me" (Negative Perception).

Table 14. Comment Categories and Subcategories.

Reasons for Not Seeking Therapy	*n*	Reasons for Seeking Therapy	*n*
No need	57	Personal Growth	7
Barriers	19	Relationships	16
Time	4		
Money	6		
Don't believe	1		
No referral	1		
Laziness	2		
Fear	1		
Other support	8	Symptom Relief	16
Required therapy	10	Stressors	5
Can solve own problems	10	Considered Counseling	1
Self-Care	4	Positive Perceptions	1
Negative Perceptions	11	Career Counseling	1
Stigma	6	Academic Concerns.	1
Privacy	2	Medication	1
Anti-Counselor	2	Identity	1

CHAPTER V

DISCUSSION

Men's difficulty in initiating therapy has been documented for more than two decades (Blazina & Watkins, 1996; Chamow, 1978; Good & Wood, 1995). Addis and Mahalik (2003) stated, "Men's relative reluctance to seek help stands in stark contrast to the range and severity of the problems that affect them" (p. 6). It is because of this documented difficulty men have in seeking help, and the problems that result from this reluctance, that this study was needed. The fact is, although men are less likely to seek help, men still do seek therapy. The purpose of this study was to compare college men who have sought therapy with college men who have not sought therapy. Many of the past studies have focused on men's attitudes towards seeking therapy, though no past studies have focused on men who have sought therapy. The men who have sought therapy and those who had not were compared on five variables, using five different scales: (1) depression (CES-D), (2) loneliness (UCLA), (3) gender role conflict (GRCS), (4) attitudes towards help seeking (ASPPH), and (5) psychological symptoms endorsed (HSC). Whereas there is much literature on men who have not sought therapy, the unique aspect of this study is that it used a sample that had sought therapy in its comparisons.

The sample was comprised of undergraduate and graduate students at three universities: University of North Dakota, North Dakota State University, and University of Missouri – Kansas City. College students were chosen because much of the literature leading up to the hypotheses of this study was based on a college student population.

College students were also used because it was methodologically possible to recruit men who have and have not sought therapy from the same population. College men who had sought therapy were recruited through the university counseling centers. Male clients were provided with a flier that had information about the study and a web link to complete the survey on-line. Men were also recruited via e-mail. The majority of these men were recruited with the thought that they would probably be in the non-clinical sample, but were placed in the clinical sample if they had sought therapy (as reported on the demographics form).

The main analyses used a binary logistic regression to determine if it was possible to predict whether or not a participant had sought therapy based on the five predictors. The main hypothesis was that gender role conflict, loneliness, depression, attitudes towards help seeking, and psychological symptoms would all be significant predictors of two categories of group membership: men who have sought therapy and men who have not sought therapy. This hypothesis was partially supported. It was found that group membership could be significantly predicted, but only attitudes towards help-seeking and loneliness were significant predictors. The model had an overall prediction rate of 80.7% and successfully predicted 77.3% of the clinical group and 84.1% of the non-clinical group.

The main analyses described above will be described in detail later in this chapter. The chapter will begin with a discussion of the sampling procedures and the abridged sample. The second portion of the chapter will include discussion related to the preliminary analyses based on demographic variables. Preliminary analyses included examination of race/ethnicity, educational level, estimated self income, estimated

parental income, age, hours worked per week, relationship status, living situation, and on/off campus work. These preliminary analyses were conducted to determine if these demographic variables influenced the predictors of the main analyses. The next portion of the discussion section will focus on the main analyses, the binary logistic regression. Also, an examination of the secondary hypotheses will follow this discussion.A discussion of the correlations between the scales and subscales will follow. In addition, the participants were asked to write in comments about help-seeking and these qualitative comments will be discussed. These comments provide additional information about what leads men or prevents men from seeking therapy. The end of the chapter will examine how the results of this study may apply to theory, practice, and research. Future research and limitations of the study will conclude the chapter.

Abridged Sample

As indicated above, the sample for this study was recruited via two methods. The first method was to provide male clients of three university counseling centers with fliers/invitations to participate in the study. The second recruiting method was to send e-mails to a random sample of university men at the same three universities. The study design did not include a way to track how many participants were recruited via each method, but it is assumed that a majority of the clinical sample was obtained through the counseling centers. After recruitment was conducted for approximately one year, the sample included complete data for 44 men who had sought therapy and 114 men who had not sought therapy. It is important to note that 500 e-mails were sent out to participants at each of three schools (1500 total, 7.6% yield rate). It is also important to note that the way participants were recruited at counseling centers varied by site. Some therapists

provided their clients with the materials, and other therapists had the fliers available on their information table for the participant to pick up if interested.

Due to the uneven number of participants who had sought therapy and those who had not sought therapy, the group of men who had not sought therapy was split into two groups. A random sample of the 114 non-clinical participants was obtained using a random number generator to obtain 44 men who had not sought therapy. Results of the analysis between the abridged sample and the non-clinical sample that was not used indicated that the abridged sample is a representative sample of the larger non-clinical sample. The analyses indicate that the two non-clinical groups do not differ on any of the scales or subscales used to run the preliminary analyses, main analysis, or secondary hypotheses. All of the results discussed below in this chapter and described in the results section are based on comparisons between the 44 men in the clinical sample and the 44 men in the abridged non-clinical sample.

Preliminary Analyses

Participants began the study by completing a demographics form. Preliminary analyses were conducted using these demographic variables to determine if participant status on these variables influenced responses to the scales and subscales used in the main analyses and the analyses of the secondary hypotheses. The demographic variables of education level, relationship status, living situation, work situation (on/off campus), work hours per week, and age all produced significant results on some of the dependent variables. Discussion of these variables will be examined below. There were no significant differences based on race/ethnicity, estimated self income, or estimated parental income.

These preliminary analyses were used to determine how demographic variables do or do not influence the participant's gender role conflict, depression, psychological symptoms, loneliness, and attitudes towards help seeking. There were significant results related to relationship status, living situation, age, and hours worked per week. In the case of this study, the significant demographic variables were not added as predictors to the main analysis due to the limited variation of the participants on these demographic variables and the decreased power of the main analysis if more predictors were added. It is important to use the preliminary results with caution, as in many cases the diversity of the sample was limited. In an attempt to explore the diversity of the sample, subgroups were identified that were sometimes very small. For example, only 3% of the participants indicated that they had been divorced and 85% of the sample identified as Caucasian/White. Also, because the sample solely consisted on men in college there was a restricted range on variables such as age and income.

Relationship status. The first significant preliminary analysis found that there are significant differences in psychological symptoms across relationship status. The results indicate that men who are divorced have significantly higher levels of symptomatology (based on the HSC) than men who are dating, single, or partnered. The results also indicated that divorced men had significantly higher levels of depression (based on the HSC-Dep and CES-D) than men who are single, dating, or partnered. Higher levels of somatic complaints (HSC-Som) and obsessive-compulsive symptoms (HSC-OC) were also found among divorced men, when compared to men who were single, dating, or partnered.

These results indicate that men who are divorced had significantly higher levels of symptomatology when compared to their male counterparts. From these results it is not possible to determine if men who are divorced have increased symptomatology as a result of the divorce or if their symptomatology is present during the partnership and leads to a divorce. It is also possible that some of the symptomatology was present before the divorce and exacerbated by the situational distress of the divorce. It is also not known how much the amount of time since the divorce varied among participants. This data would be helpful to determine whether or not the symptomatology is an adjustment to a new stressor (i.e., adjustment disorder with depressed mood) or is a more chronic state. The results lead to speculation about the need for couples counseling in these men. Doss, Simpson, and Christensen (2004) explored why couples seek counseling and found that the most commonly reported reasons for seeking marital therapy in their were interpersonal difficulties, especially communication problems and lack of emotional affection. The authors also found that men and women in the same couple often differ on their view of what the problem is and that often couples wait to seek couples counseling long after the problem begins. For the current study, it is important to note that the results should be interpreted with caution, as the number of divorced men in the sample was less than 5. Before any conclusions are made based on these results, it would be important to increase the number of divorced men in the sample.

It was also found that men who identified as single scored significantly higher on loneliness than men who were dating. There were no significant differences on loneliness between men who were single and those that were divorced or partnered. The results suggest that college men may feel more connected socially when they are dating. It is

unclear why this difference would not hold true for men that are partnered. Femlee (2001) conducted a study that examined the social network and its response to new romantic relationships. The main argument of the study is that friends and social network play a large role in the success or failure of a relationship. In a qualitative portion of the study she found that friends of people involved in new relationships often stated that they disapproved of the relationship due to the amount of time it takes away from them being able to spend with the friend. Femlee (2001) concludes that social networks can have positive effects on the relationship, but that they also can have negative effects on the quality and longevity of the relationship.

Educational Level. One-way ANOVAs indicated that there was an overall effect of educational level on the men's attitudes towards seeking professional psychological help. Although there was an overall effect, post-hoc analyses did not indicate any significant differences between men at varying educational levels. This is likely a result of a low number of participants in each group; and a larger sample size with similar results would increase power, and therefore increase the likelihood of statistical difference. Also, when examining the post-hoc results there were not any differences that were approaching significance. Because of these varying results, it is prudent to conclude that educational level did not influence the men's help seeking attitudes in this sample. If the sample size were increased, it may be prudent to look at the differences in attitudes between doctoral and professional students. The difference on confidence in mental health practitioners is large, although not statistically significant, in this sample.

Living situation. Significant differences were found between men who reported living in fraternity homes and men who lived in other campus housing on help seeking

attitudes. Men who lived in fraternity homes were less likely to have favorable attitudes towards help seeking than men who lived in other campus housing. These results may provide some information for future study, but should be interpreted with caution as the number of participants in each of these groups is very small. This result may be indicative of the age difference between the men who live in fraternity housing ($M = 18.667$, $SD = 0.577$) and other campus housing ($M = 26.750$, $SD = 7.611$). If this result would remain stable with a larger sample size, it would demonstrate the increased importance of counseling center outreach in fraternities. On many campuses fraternity members are leaders and active in the community, and interventions and outreach that would improve their attitudes towards help seeking may have larger effects on other campus men. As noted in the next subsection, men who reported a higher age had more positive attitudes towards seeking professional psychological help. There were no significant differences between the other living situations: with family or other relatives, other private home, college residence hall, or other living situations.

Age. Age was found to significantly correlate with the participants' homophobia, recognition of the need for mental health services, interpersonal openness, and confidence in mental health professionals. It was found that homophobic attitudes were more present in the younger men in the sample, although the age range of the sample was skewed towards younger. These results are similar to results reported in O'Neil, Good, and Holmes (1995), which found that men in their late twenties and early thirties have more difficulty expressing and receiving emotions from men than older men, except that men in the current sample were concentrated in their late teens and early twenties. O'Neil et al. also found that men who indicated an older age were less likely to recognize the

need for mental health professionals and have less confidence in mental health professionals, opposite results from the current study; again their sample was older than the current sample. The current findings were partially validate a Mackenzie, Gekoski, and Knox (2006) study that found older participants more readily sought help for mental health concerns, but typically from primary care physicians. The sample included 105 men and 99 women who ranged in age from 18-89, with a mean of 46.1 (SD = 17.7) and 24.5% of participants age 60 and above; a significantly greater range of ages than the current study's sample. Mackenzie et al. suggest that more informal education or information may be needed in order to help older individuals recognize the need and purpose of mental health professionals.

Hours of work per week. The only significant finding based on number of hours worked per week was that men who reported working more reported more negative family relations. This finding supports what would be expected. Also, Marshall and Barnett (1993) found that work-family strain is more common when the workload is greater at work or at home. This result should be interpreted with caution, as the number of hours worked per week is based on the hours worked at a job. This result may be confounded by the variability of time spent working on school work by the college men in this sample. The number or school work hours was not asked, and therefore some men may have worked more combined school and work hours, but worked less often at employment sites.

Summary. The preliminary analyses provide some context for the variety of variables that may or may not influence the men's responses to the scales and subscales used in the main analysis. As noted above, many of the results found to be significant

were based on very small sub-samples. For this reason, these variables were not used as predictors in the main analysis. Future research would be required on each of the demographic variables before any conclusions should be drawn.

Main Hypotheses

The main hypothesis was that gender role conflict, loneliness, depression, attitudes towards help seeking, and psychological symptoms would all be significant predictors of two categories of group membership: men who have sought therapy and men who have not sought therapy. This hypothesis was partially supported. It was found that group membership could be significantly predicted, but only attitudes towards help-seeking and loneliness were significant predictors. The model had an overall prediction rate of 80.7% and successfully predicted 77.3% of the clinical group and 84.1% of the non-clinical group. If the predictors added nothing to the model, the prediction would be 100% accurate, with 50% of the group in the non-clinical sample and 50% of the group in the clinical sample (null hypothesis). The results indicate a significant change from this null hypothesis (Grerson, 2006).

The two significant predictors were loneliness and attitudes towards professional psychological help. Loneliness was measured by the UCLA Loneliness Scale. The results indicated that men who had sought therapy were significantly lonelier than men who had not sought therapy. This finding adds to past research that indicated that men who are in counseling had significantly higher levels of loneliness than women in counseling (Wiseman, Guttfreund, & Lurie, 1995). The results demonstrate that this difference on loneliness can help to predict whether or not a man will seek therapy. It is also important to note that what determines whether or not a man considers himself lonely may differ

from a woman's perspective. Wiseman, Guttfreund, and Lurie (1995) stated that it may be more acceptable for male counseling seekers to acknowledge social isolation, whereas women would be more likely to acknowledge symptoms of depression. Hale, Hannum, and Espelage (2005) found that men's having a sense of connection to a group of others is a key support component for the physical health of college students. Vogel and Wei (2005) stated that people with weaker social support networks have been more likely to seek help. Vogel and Wei found that perceived social support is an important mediating variable in whether or not college students will seek help.

Stokes and Levin (1986) found that men base whether or not they are lonely on the number of friends they have, and often men are more focused on the number of friends and the types of activities they have in common. Women often base their friendships on social intimacy, and the amount of friends is less important. As college is a time of expanding friendships, it may be that some men are having a difficult time finding a group of friends to participate in activities with or it may be that men are searching for more intimate relationships with men -- some of the emotional needs that can be met in therapy. Bank and Hansford (2000) examined the factors that contribute to men having less intimate and supportive friendships than women. The authors found that men's best friend relationships had significantly lower levels of intimate friendship, one's feelings of concern and affection for that friend, and supportive friendship, the amount of support received from one's best friend. Bank and Hansford (2000) found that emotional restraint and homophobia were the most influential mediators between gender and intimate and supportive friendship. These findings support the fact that men may have

less emotional support and intimacy in their friendship relationships and that often men base their friendships on activity rather than emotional intimacy.

The second significant predictor was attitudes towards seeking professional psychological help. The results for attitudes towards help seeking indicated that men who had sought therapy had more favorable attitudes towards seeking professional psychological help than men who had not sought therapy. The direction of this relationship is as predicted. One possible alternative explanation for the more positive attitudes towards help seeking in the clinical sample is cognitive dissonance. It is possible that men that seek therapy have to overcome a significant hurdle to seek therapy, and because of this increase positive attitudes are formed to justify or compensate for their decision. This finding will be further discussed in greater depth later in the chapter.

Secondary Hypotheses

The first secondary hypothesis is that men who have sought therapy will have lower scores on gender role conflict. This hypothesis was not supported for the overall gender role conflict score or the subscales of the Gender Role Conflict Scale (GRCS). Blazina and Watkins (1996) found that men who scored higher on the GRCS view seeking help more negatively than men who scored lower on the GRCS, and Good and Wood (1995) found that restriction-related male gender role conflict accounted for 25% of the variance in help-seeking attitudes. O'Neil, Good, and Holmes (1995) also stated that there is strong evidence for the relationship between men's gender role conflict and negative help-seeking attitudes. It is important to note that all of these studies based their findings on the attitudes of the participants towards help seeking. One possible explanation for this finding is that men in college have lower levels of gender role

conflict due to their education. Another possible reason is that the men in this study answered in a socially desirable way when completing the GRCS. The intention of the questions on the GRCS can easily be interpreted by the participant, and there is a chance that the men answered in a way that they believe they were "supposed to."

The second secondary hypothesis is that men who sought therapy will have more depressive symptoms than men who had not sought therapy. This hypothesis was supported (as measured by the CES-D). These higher levels of depression are expected, as many of the participants were currently in therapy and many of them may not have been in therapy long enough for depressive symptoms to have alleviated. The NIMH (2000) stated that depressive disorders affect 9.5% of the population in any given year or about 20.9 million adults. Therefore the amount of depressive symptoms in the clinical sample is not surprising.

The third secondary hypothesis was that men who have sought therapy will have more positive attitudes regarding professional psychological help than men who have not sought therapy. The results indicated that this was true. Not only did men who have sought therapy have more positive overall attitudes towards seeking psychological help, they also had more confidence in mental health professionals and were more likely to recognize the need for therapy. Fisher and Turner (1970) found in their norming sample that individuals that have had professional contact had more positive attitudes towards help seeking than men who have had no professional contact. The results, however, indicated no difference between men who have sought therapy and have not sought therapy on stigma tolerance (ASPPH ST).

The fourth secondary hypothesis is that men who have sought therapy will have higher levels of psychological symptoms than men who have not sought therapy. This result was fully supported. It was found that men who have sought therapy had higher levels of overall symptomatology, were more interpersonally sensitive, and had higher levels of somatic complaints, obsessive-compulsive symptoms, depression, and anxiety. These results are important because they may help clinicians understand what brings men into therapy. It seems common sensical that men in therapy have higher symptomatology than men not in therapy, as the symptomatology that the men present with may be a primary reason in seeking therapy. These results also match the norming samples provided by Derogatis et al. (1974) that demonstrate that the clinical samples used have higher scores than non-clinical samples.

The fifth secondary hypothesis was that men who have sought therapy will have higher levels of loneliness than men who have not sought therapy. The results indicated that this hypothesis was supported. This finding may demonstrate that men who are isolated or lack social support may be more likely to seek therapy. These results have been previously discussed during the discussion of the main analysis.

The last secondary hypothesis predicted that symptoms endorsed, loneliness, depression, and gender role conflict would significantly predict attitudes towards help seeking. This hypothesis differs from previous hypotheses because both the clinical group and non-clinical group are collapsed into one group. This hypothesis was partially supported. It was found that in a multiple regression these four predictors accounted for 18.9% of the variance in attitudes towards help seeking. Further examination of the results indicated that the only significant predictor was gender role conflict, which

accounted for 14.8% of the variance on attitudes towards help seeking. When comparing gender role conflict with attitudes towards seeking professional help, it was determined that as gender role conflict increased, attitudes towards seeking help decreased. As noted previously in the chapter, gender role conflict significantly predicted help-seeking attitudes, but did not significantly predict help-seeking behavior. Future research should address this contradiction and use methodology to examine a possible path with gender role conflict predicting help-seeking attitudes, which then predict help-seeking behavior.

Correlations

Bivariate correlations were run between the scales and subscales. Some of the notable correlations will be discussed and possible implications of these correlations will be noted. The HSC measured overall psychological symptoms. As predicted, the HSC was positively correlated with its five subscales: depression, anxiety, obsessive-compulsive, interpersonal openness, and somatization. The overall HSC score was also significantly positively correlated to the CES-D and the UCLA. These correlations demonstrate the relationships among all of the scales that addressed psychological symptoms. They provide evidence that men who are in distress and endorse psychological symptoms often endorse symptoms related to several different clinical disorders. It is important to note that although all of these scales were positively correlated, the data do not provide sufficient evidence of to diagnose any specific disorder. Many of the HSC subscales use the same label as DSM-IV diagnoses, but there is no research to indicate that a certain score on the HSC indicates the presence of a disorder at a clinically significant level.

The GRCS also showed significant correlations with all of the other scales and most of their subscales. As noted above, gender role conflict was negatively correlated with attitudes towards seeking psychological help. Specifically, restricted emotionality and discomfort with emotions shared with other men were negatively correlated with attitudes towards seeking professional psychological help. Good and Wood (1995) found that restriction related gender role conflict accounted for 25% of the variance in attitudes towards seeking psychological help. In the current study, gender role conflict accounted for 14.8% of the variance in attitudes towards seeking psychological help. The results of the current study demonstrated that higher gender role conflict was related to men feeling more stigmatized by seeking professional psychological help. Also, the men in the current study who reported higher gender role conflict were less interpersonally open, according to the interpersonal openness subscale of the ASPPH (ASPPH-Interper).

The loneliness (UCLA) and depression (CES-D) scales in this study were positively correlated. Wiseman et al. (1995) stated that men are more likely to report loneliness and women are more likely to endorse depression. They argue that this may be the result of a difference in how men and women respond to depression and loneliness, and may be indicative of a similar construct. They argue that women's depression and men's loneliness may both be manifestations of an overarching construct. This positive correlation may suggest that loneliness and depression are similar in men or that loneliness in men leads to depression. It would be important for future research to examine the relationship or comorbidity of loneliness and depression in men. Another possibility is that it is easier for men to recognize or acknowledge loneliness than

depression (Wiseman et al., 1995). It is possible that loneliness may indicate something social, rather than a sign of weakness or something psychological.

Implications for Theory, Practice, and Research

The results of this study have important implications for theory, research, and practice. This study's unique contribution to the literature is its comparison of men who have sought therapy to men who have not sought therapy. There have been many studies in the past that have looked at males' motivation to seek help (Blazina & Watkins, 1996; Good & Wood, 1995). These studies have found that men are less likely to seek help if they have higher levels of gender role conflict (Good & Wood, 1995).

The implications from this study on theory regarding men's motivation to seek help are great. It was found that men who have sought therapy have more positive attitudes about seeking psychological help. It is unclear if men in this study had more positive attitudes than men who do not seek therapy when they first sought therapy, or if their attitudes became more favorable as time in therapy increased. The major finding that contradicts current gender role conflict theory (O'Neil, Good, & Holmes, 1995) is that whereas men in therapy are theorized to have lower levels of gender role conflict, this study found that men who have sought therapy and men who have not sought therapy do not have differing levels of gender role conflict.

The most discrepant finding in this study, in relation to previous studies, is that in the main analysis the only significant predictors of help-seeking behavior were attitudes towards help-seeking and loneliness. Gender role conflict was not a significant predictor in the prediction of whether or not a man has sought therapy. The secondary hypothesis that predicted attitudes towards help seeking found that gender role conflict was the only

significant predictor of attitudes towards help seeking. Possible explanations include that gender role conflict predicts attitudes, and then attitudes predict behavior. Future studies should examine whether or not this path can be substantiated and validated.

The other factor that significantly played a role in predicting whether or not men sought therapy was loneliness. Examples of UCLA items included "How often do you feel like you lack companionship?" "How often do you feel that people are around you but not with you?" and "How often do you feel that there are people you can turn to?" Results from this study suggest that men may come to therapy when they are feeling socially isolated and have no one else to talk to. Clinical implications of this line of reasoning include the possibility that men will wait until their level of distress is high and may come to therapy looking for an answer to this distress. It also may mean that when men come to therapy they are actually more focused on the relationship with the therapist as a means of support.

Collectively, these findings may demonstrate the need for college counseling centers to have strong outreach programs that reach a large population of the campus. This outreach needs to reach men that are socially isolated and have little or no involvement in organizations or clubs. The results also suggest the importance of outreach in fraternities, which often are very socially oriented. It also points to the importance of the relationship between the college counseling center and other staff and faculty. It may be resident assistants, faculty members, and administrative staff that have the closest contact with men that are more socially isolated. They may serve as an important referral source for men to seek therapy. Oliver, Reed, Katz, and Haugh (1999) found that both men and women are more likely to talk to informal helpers (e.g., family,

friends, teacher) than formal helpers. Rochlen, Blazina, and Raghunathan (2002) suggest that men's attitudes towards career counseling can be changed by educating the men and providing clear descriptions of how career counseling works. Although their findings were specific to career counseling, education to staff and students through outreach that provides clear descriptions of counseling may lessen the stigma of seeking psychological help.

The implications for research based on this study are clear. It is important to continue to use college men who have sought therapy in the studies conducted about men's mental help-seeking. The results demonstrate that attitudes towards help seeking and loneliness significantly predict group membership between men who have and have not sought therapy. The lack of influence of gender role conflict may indicate that this is less influential in the actual help-seeking behaviors of men. It seems that gender role conflict does have an influence on the attitudes towards help seeking, but in this study id did not directly influence help-seeking behavior. Future research should focus on examining men who have sought therapy and what influenced them to seek therapy. Obtaining a clinical sample of men was difficult, and the results may be influenced by men who self-selected into the study. Future research may want to try accessing existing data collected by college counseling centers, so that the results are more representative of all men that seek counseling at the center (with informed consent).

Future Research

The results of this study provide several options for future research. The first area of future research involves exploring the attitudes regarding help seeking longitudinally. The current study does not provide information about the attitudes towards therapy at

intake, and whether these change as time in therapy increases. This would be important to study because it may be that men come to therapy with negative attitudes and their attitudes improve with a positive therapy experience. On the other hand, it may be that men who enter therapy already have positive perceptions of seeking help. Future studies should focus on using a clinical sample that is all at a similar point in therapy, most likely intake, and then reassess their attitudes at termination. It is often the case that clients do not have an assigned termination session, so it may be beneficial to reassess the clients every few weeks or sessions.

One area that may provide a clearer understanding is to further explore the relationship between loneliness and men who seek help. This study found that men who sought therapy had greater levels of loneliness than men who did not seek therapy. This may be related to a lack of social support that the men have. It also may be related to a lack of emotional support, even though they have friends. It seems that men often feel that they have social support, in terms of having friends to hang out with, but lack friends that they can share emotional problems with. Veniegas and Peplau (1997) found that women rate their same-sex friendships higher in quality than men and men used self-disclosure less frequently than women. These results may suggest that men who are in distress and have a limited number of friendships in which they can self-disclose may seek therapy for that source of support. Future research may help determine if the social isolation or loneliness is related to a lack of emotional intimacy with friends and partners or reflects a lack of social support.

The main area of future research should focus on helping determine what leads men to seek therapy. Given the design of this study, the question of what got men to seek

therapy remains unanswered. It may be helpful to do a qualitative study of men who have sought therapy. In this qualitative study it would be helpful to question the participants about their thought process regarding seeking therapy, their emotional experiences, and what led or pushed them to seek therapy. Pollack and Levant (1998) address six factors that seem to keep men from attending therapy. The first factor is difficulty admitting there is a problem. In the current study the most common qualitative comment related to not needing therapy. It is likely that many of these men do not need therapy, but it is also possible that some of these men do have problems that therapy could address but have difficulty admitting a problem. The second factor is difficulty in asking for help and depending on others. A qualitative example from this study was, "I believe that I can handle my problems on my own." The third factor is difficulty identifying and processing vulnerable and caring emotions. A comment from this study from one participant that echoed this factor was, "I am not comfortable sharing my feelings and closely held beliefs with a stranger." The fourth factor is a fear of intimacy. The fifth factor is either sexualization of encounters with female therapists or homophobic barriers in encounters with male therapists. A related qualitative comment from this study was, "It is too gay for me." The last factor is lack of therapeutic treatments that are empathetic to men's needs (Pollack & Levant, 1998).

Gender role conflict research has been a major influence on the design and implications of this study. The past research (i.e., Good & Wood, 1995) has indicated that men with higher levels of gender role conflict, or more traditional gender roles, will have more negative attitudes towards seeking help. Heppner (1995) stated that gender role conflict is positively related to psychological maladjustment. This statement was

supported in the current study by positive correlations between gender role conflict (GRCS) and psychological symptomatology (HSC), depression (CES-D), and loneliness (UCLA). These results continue to demonstrate the importance of work with men to lower gender role conflict. These results would not only improve the physical and emotional health of men, but also would lead to improved relationships with men and women.

Limitations

The main limitation of this study is the sample. The sample for the study was self-selected, therefore making it possible that men who participated in the study are not representative of all men who attend therapy. It was very difficult to find a way for the researcher to recruit participants in the therapy subsample, as one of the foundations of therapy is confidentiality. The researcher had to rely on counseling center staff to provide information about the study to participants. It then required the men to take the information and complete the study on their own time. It may be helpful in future research to have an arrangement with the counseling center to have the participant complete the study at the center or to use data that is collected for internal purposes. It may be helpful to provide the therapist with some of the data, with the client's consent, therefore providing a benefit to the therapist and client. For example, it may be helpful for the therapist to have information about the client's gender role conflict, levels of loneliness, and attitudes towards help seeking in order to tailor the treatment to the client.

Due to the difficulty of recruiting men who had sought therapy, the second limitation of the study is the small sample size. In order to account for this small clinical sample size it was necessary to randomly select from and therefore not utilize a majority

of the potential members of the non-clinical sample. Ideally, in future studies it would be possible to increase the clinical sample. The limited sample also included the limitation of a rather homogeneous sample. The small numbers in several of the demographic groups limit the generalizability of the findings to non-traditional students and students of color.

Another limitation to the study is the rudimentary review of the qualitative comments. The qualitative comments add a distinct flavor to the findings of this study and provide real-world examples of many of the variables studied. The review of these comments was done by the primary investigator and coded into categories based on their content. This coding was then reviewed by the dissertation chair. This review provides us the ability to use the comments to enhance some of the quantitative findings, but should be used with caution when generalizing to other samples or men in general. A more complex qualitative study is suggested in the future research section, and a more rigorous qualitative methodology would be suggested.

Conclusion

This study provides additional information regarding men's help-seeking behaviors and what leads men to seek help. As was noted above, results indicate that lonely men are more likely to seek therapy and men who have more positive attitudes about seeking psychological help are more likely to seek therapy. This expands past research that has found the relationship between gender role conflict and attitudes about seeking psychological help, but with a non-clinical sample. Future research should continue to use men who seek therapy in the sample, as it will provide researchers and

therapists alike with a clearer picture of men in therapy and their motivations to seek therapy.

A better understanding of men's help seeking behavior is vital to the health of men. As noted in the introduction, Addis and Mahalik (2003) stated, "Men's relative reluctance to seek help stands in stark contrast to the range and severity of the problems that affect them" (p. 6). Some of the provided examples include the fact that men die on average 7 years before women and have higher rates of the 15 leading causes of death. Men's reluctance to seek help has effects on their mental and physical health. Men's reluctance to seek help also can have negative effects on their relationships with other men and women.

O'Neil and Harway (1997) stated that men's patterns of gender role conflict (i.e., control, power, competition, and restrictive emotionality) contribute to patterns of violence towards women. The authors argued that when men's success, power, and competition are threatened by their partner, in extreme cases the man may react with violence or control to protect their masculine self-esteem. Also, men's inability to express their emotions may lead to men using violence to convey their feelings. A better understanding of men's help seeking behaviors would be beneficial for both men and women.

APPENDICES

APPENDIX A

GENDER ROLE CONFLICT SCALE - I

Instructions: In the space to the left of each sentence below, write the number that most closely represents the degree that you Agree or Disagree with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

Strongly Agree					Strongly Disagree
6	5	4	3	2	1

1. ____ Moving up the career ladder is important to me.
2. ____ I have difficulty telling others I care about them.
3. ____ Verbally expressing my love to another man is difficult for me.
4. ____ I feel torn between my hectic work schedule and caring for my health.
5. ____ Making money is part of my idea of being a successful man.
6. ____ Strong emotions are difficult for me to understand.
7. ____ Affection with other men makes me tense.
8. ____ I sometimes define my personal value by my career success.
9. ____ Expressing feelings makes me feel open to attack by other people.
10. ____ Expressing my emotions to other men is risky.
11. ____ My career, job, or school affects the quality of my leisure or family life.
12. ____ I evaluate other people's value by their level of achievement and success.

Strongly Agree					Strongly Disagree
6	5	4	3	2	1

13. ____Talking about my feelings during sexual relations is difficult for me.

14. ____ I worry about failing and how it affects my doing well as a man.

15. ____ I have difficulty expressing my emotional needs to my partner.

16. ____ Men who touch other men make me uncomfortable.

17. ____ Finding time to relax is difficult for me.

18. ____ Doing well all the time is important to me.

19. ____ I have difficulty expressing my tender feelings.

20. ____ Hugging other men is difficult for me.

21. ____ I often feel that I need to be in charge of those around me.

22. ____ Telling others of my strong feelings is not part of my sexual behavior.

23. ____ Competing with others is the best way to succeed.

24. ____ Winning is a measure of my value and personal worth.

25. ____ I often have trouble finding words that describe how I am feeling.

26. ____ I am sometimes hesitant to show my affection to men because of how others might perceive me.

27. ____ My needs to work or study keep me from my family or leisure more than would like.

28. ____ I strive to be more successful than others.

29. ____ I do not like to show my emotions to other people.

30. ____ Telling my partner my feelings about him/her during sex is difficult for me.

Strongly Agree					Strongly Disagree
6	5	4	3	2	1

31. ____ My work or school often disrupts other parts of my life (home, family, health leisure.

32. ____ I am often concerned about how others evaluate my performance at work or school.

33. ____ Being very personal with other men makes me feel uncomfortable.

34. ____ Being smarter or physically stronger than other men is important to me.

35. ____ Men who are overly friendly to me make me wonder about their sexual preference (men or women).

36. ____ Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life.

37.____ I like to feel superior to other people.

APPENDIX B

CES-D

Select the answer that best describes your situation over the past week.

0 = Rarely or none of the time (less than 1 day)
1 = Some or little of the time (1-2 days)
2 = Occasionally or a moderate amount of the time (3-4 days)
3 = Most or all of the time (5-7 days)

During the Past Week:		0	1	2	3
1.	I was bothered by things that usually don't bother me.	◉	○	○	○
2.	I did not feel like eating; my appetite was poor.	◉	○	○	○
3.	I felt that I could not shake off the blues even with help from my family or friends.	◉	○	○	○
4.	I felt that I was just as good as other people.	◉	○	○	○
5.	I had trouble keeping my mind on what I was doing.	◉	○	○	○
6.	I felt depressed.	◉	○	○	○
7.	I felt that everything I did was an effort.	◉	○	○	○
8.	I felt hopeful about the future.	◉	○	○	○
9.	I thought my life had been a failure.	◉	○	○	○
10.	I felt fearful.	◉	○	○	○
11.	My sleep was restless.	◉	○	○	○
12.	I was happy.	◉	○	○	○
13.	I talked less than usual.	◉	○	○	○
14.	I felt lonely.	◉	○	○	○

15.	People were unfriendly.	◉	○	○	○
16.	I enjoyed life.	◉	○	○	○
17.	I had crying spells.	◉	○	○	○
18.	I felt sad.	◉	○	○	○
19.	I felt people disliked me.	◉	○	○	○
20.	I could not get "going".	◉	○	○	○

APPENDIX C

ASPPH

Circle a response for each of the statements. The term therapist may include counselors, psychologists, or any other mental health professionals.

	0 Agree	1	2	3 Disagree
1. Although there are clinics for people with mental troubles, I would not have much faith in them.	0	1	2	3
2. If a good friend asked my advice about a mental problem, I might recommend that he see a therapist.	0	1	2	3
3. I would feel uneasy going to a therapist because of what some people think.	0	1	2	3
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a therapist.	0	1	2	3
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.	0	1	2	3
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychological treatment.	0	1	2	3
9. Emotional difficulties, like many things, tend to work out by themselves.	0	1	2	3
10. There are certain problems which should not be discussed outside of one's immediate family.	0	1	2	3
11. A person with serious emotional disturbance would probably feel most secure in a good mental hospital.	0	1	2	3
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3
14. Having been a psychological patient is a blot on a person's life.	0	1	2	3
15. I would rather be advised by a close friend than by a therapist, even for an emotional problem.	0	1	2	3
16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.	0	1	2	3
17. I represent a person-professionally trained or not-who wants to know about my personal difficulties.	0	1	2	3
18. I would want to get psychological attention if I was worried or upset for a long period of time.	0	1	2	3
19. The idea of talking about problems with a therapist strikes me as a poor way to get ride of emotional conflicts.	0	1	2	3
20. Having been mentally ill carries with it a burden of shame.	0	1	2	3
21. There are experiences in my life I would not discuss with anyone.	0	1	2	3
22. It is probably best not to know everything about oneself.	0	1	2	3
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.	0	1	2	3
25. At some future time I might want to have psychological counseling.	0	1	2	3
26. A person should work out his own problems; getting psychological counseling would be a last resort.	0	1	2	3
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	0	1	2	3
28. If I thought I needed psychological help, I would get it no matter who knew about it.	0	1	2	3
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	0	1	2	3

APPENDIX D

UCLA LONELINESS SCALE

The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by selecting the appropriate number.

1	2	3	4
Never	Rarely	Sometimes	Always

1. How often do you feel that you are "in tune" with the people around you? 1 2 3 4
2. How often do you feel that you lack companionship? 1 2 3 4
3. How often do you feel that there is no one you can turn to? 1 2 3 4
4. How often do you feel alone? 1 2 3 4
5. How often do you feel part of a group of friends? 1 2 3 4
6. How often do you feel that you have a lot in common with the people around you? 1 2 3 4
7. How often do you feel that you are no longer close to anyone? 1 2 3 4
8. How often do you feel that your interests and ideas are not shared by those around you? 1 2 3 4
9. How often do you feel outgoing and friendly? 1 2 3 4
10. How often do you feel close to people? 1 2 3 4
11. How often do you feel left out? 1 2 3 4
12. How often do you feel that your relationships with others are not meaningful? 1 2 3 4
13. How often do you feel that no one really knows you well? 1 2 3 4
14. How often do you feel isolated from others? 1 2 3 4
15. How often do you feel you can find companionship when you want it? 1 2 3 4
16. How often do you feel that there are people who really understand you? 1 2 3 4
17. How often do you feel shy? 1 2 3 4
18. How often do you feel that people are around you but not with you? 1 2 3 4
19. How often do you feel that there are people you can talk to? 1 2 3 4
20. How often do you feel that there are people you can turn to? 1 2 3 4

APPENDIX E

HOPKINS SYMPTOM CHECKLIST

Instructions
Below is a list of symptoms and complaints that people sometimes have. Read each question carefully, then, using the scale shown below, select one of the numbered descriptors that best describes how much discomfort that problem has caused you during the past week including today. Indicate your choice by circling one number in the scale beside each item. Do not skip any items.

0	1	2	3
Not at All Distressed	A Little Distressed	Quite a bit Distressed	Extremely Distressed

1. Headaches	0	1	2	3
2. Nervousness or shakiness inside	0	1	2	3
3. Being unable to get rid of bad thoughts or ideas	0	1	2	3
4. Faintness or dizziness	0	1	2	3
5. Loss of sexual interest or pleasure	0	1	2	3
6. Feeling critical of others	0	1	2	3
7. Bad dreams	0	1	2	3
8. Difficulty in speaking when you are excited	0	1	2	3
9. Trouble remembering things	0	1	2	3
10. Worried about sloppiness or carelessness	0	1	2	3
11. Feeling easily annoyed or irritated	0	1	2	3
12. Pains in the heart or chest	0	1	2	3
13. Itching	0	1	2	3
14. Feeling low in energy or slowed down	0	1	2	3
15. Thoughts of ending your life	0	1	2	3
16. Sweating	0	1	2	3
17. Trembling	0	1	2	3
18. Feeling confused	0	1	2	3
19. Poor appetite	0	1	2	3
20. Crying easily	0	1	2	3
21. Feeling shy or uneasy with the opposite sex	0	1	2	3
22. A feeling of being trapped or caught	0	1	2	3
23. Suddenly scared for no reason	0	1	2	3
24. Temper outbursts that you could not control	0	1	2	3
25. Constipation	0	1	2	3
26. Blaming yourself for things	0	1	2	3
27. Pains in the lower part of your back	0	1	2	3
28. Feeling blocked in getting things done	0	1	2	3
29. Feeling lonely	0	1	2	3
30. Feeling blue	0	1	2	3
31. Worrying or stewing about things	0	1	2	3
32. Feeling no interest in things	0	1	2	3
33. Feeling fearful	0	1	2	3
34. Your feelings being easily hurt	0	1	2	3

35. Having to ask others what you should do	0	1	2	3
36. Feeling others do not understand you or are unsympathetic	0	1	2	3
37. Feeling that people are unfriendly or dislike you	0	1	2	3
38. Having to do things very slowly in order to insure you were doing them right	0	1	2	3
39. Heart pounding or racing	0	1	2	3
40. Nausea or upset stomach	0	1	2	3
41. Feeling inferior to others	0	1	2	3
42. Soreness of your muscles	0	1	2	3
43. Loose bowel movements	0	1	2	3
44. Difficulty in falling asleep or staying asleep	0	1	2	3
45. Having to check and double check what you do	0	1	2	3
46. Difficulty making decisions	0	1	2	3
47. Wanting to be alone	0	1	2	3
48. Trouble getting your breath	0	1	2	3
49. Hot or cold spells	0	1	2	3
50. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3
51. Your mind going blank	0	1	2	3
52. Numbness or tingling in parts of your body	0	1	2	3
53. A lump in your throat	0	1	2	3
54. Feeling hopeless about the future	0	1	2	3
55. Trouble concentrating	0	1	2	3
56. Weakness in parts of your body	0	1	2	3
57. Feeling tense or keyed up	0	1	2	3
58. Heavy feelings in your arms or legs	0	1	2	3

APPENDIX F

FLIER RECRUITING PARTICIPANTS

You are being invited to participate in an on-line research study regarding men's motivation to seek therapy for the doctoral dissertation of Robert L. Reis II, M.A. Robert is a doctoral student at the University of North Dakota Department of Counseling. The survey will take approximately ½ hour to complete.

Please go to http://www.psychdata.com and enter survey #XXXX. By participating in this survey, you have the opportunity to enter a drawing for one of four $50.00 cash drawings. If you have any questions regarding this survey or are having problems accessing the survey please contact me via e-mail (Robert.reis@und.edu) or telephone (701-739-1335) or my advisor, Dr. David Whitcomb via e-mail (david.whitcomb@und.edu) or telephone (701-777-3738).

Thank you in advance for participating in my study!! Also, please remember that this study will have no effect on your relationship with the NDSU Counseling and Disability Services*.

* Name of counseling center changed based on counseling center the flier was distributed at.

APPENDIX G

E-MAIL RECRUITING PARTICIPANTS

Dear Name:

You are being invited to participate in an on-line research study regarding men's motivation to seek therapy for the doctoral dissertation of Robert L. Reis II, M.A. Robert is a doctoral student at the University of North Dakota Department of Counseling. The survey will take approximately ½ hour to complete.

Please click this link (https://www.psychdata.com/surveys.asp?SID=11376) or cut and paste the link into your internet browser to begin the survey. By participating in this survey, you have the opportunity to enter a drawing for one of four $50.00 cash drawings. If you have any questions regarding this survey or are having problems accessing the survey please contact me via e-mail (Robert.reis@und.edu) or telephone (701-739-1335) or my advisor, Dr. David Whitcomb via e-mail (david.whitcomb@und.edu) or telephone (701-777-3738).

Thank you in advance for participating in my study!!

APPENDIX H

CONSENT FORM

You have been invited to participate in a study concerning men's motivation to seek therapy. This study is for the completion of the doctoral dissertation by Robert L. Reis II, M.A. The research advisor is David Whitcomb, Ph.D., Assistant Professor of Counseling Psychology. The purpose of this project is to come to a more in-depth understanding of men's motivation to seek counseling or therapy. More specifically, interview questions will focus on past predictors that have been found to influence men's motivation for seeking therapy. Participants will be asked to complete a short demographics form and several other survey instruments. Overall, the research will take approximately one-half hour. The interview will be conducted over the internet on this secure website. The data will be available to the researcher, the research advising team, and IRB auditors. Once the data is downloaded the data will be kept secure in a locked file cabinet in the UND Department of Counseling. You are free to discontinue participation in this research study at any time without any penalty or loss of benefit.

We will actively safeguard your confidentiality in this study by not associating your name with any of the surveys that you complete. There will be no link between this consent form and the data that you complete. Survey data will be stored in locked and secured cabinet for a period of at least three years, then shredded and destroyed. Informed consent data will be collected separately and stored separately in a locked file, then destroyed after at least three years as required by law. Only researcher, research advising team, and those who make sure researchers respect the rights of research participants (Institution Review Board auditors) will have access to the data. There is a small chance that some of the information we ask may cause some discomfort. At the end of this study, counseling resources will be provided and you are encouraged to contact either of the researchers listed below for further information.

There will be no obvious direct benefit to you as a participant. You may benefit from the opportunity to think about issues related to depression, loneliness, and help-seeking in your life The benefit to society will be further knowledge about men's therapy seeking. This research hopes to examine the motivation of men who do seek therapy, and compare them to men who have not sought therapy. Also, if you desire you are welcome to provide your e-mail address for a chance to win one of four $50.00 drawings. Your e-mail address and name will not be connected in any form to your responses on the survey.

Your decision to participate in this study is strictly voluntary. If you have any concerns or questions about the study, contact Robert Reis II, M.A. (robert.reis@und.edu or 701-

739-1335) or Dr. David Whitcomb (david.whitcomb@und.edu or 701-777-3738). If you have any additional questions you can contact the University of North Dakota Institutional Review Board at (701) 777-4278. Thank you for your consideration!

****

I have read and understand the above information. I also have been given contact information for the researchers in case I have any questions. A copy of this form may be printed at this time for my records. By typing my signature below and clicking the submit button I agree to participate and understand that I may stop at any time.

Please type name:
Submitting this form will bring you to a page where you can provide your e-mail address if you would like to be included in a drawing for one of four $50 cash drawings.

SUBMIT

APPENDIX I

THANK YOU / REFERRAL PAGE

Thank you for taking the time to complete this research study. As noted in the consent form at the beginning if you have any questions or concerns please contact Robert Reis II (robert.reis@und.edu) or David Whitcomb, Ph.D. (david.whitcomb@und.edu). Below you will find a list of counseling resources available to you as a student as stated would be available in the consent form.

University of North Dakota Counseling Center (701) 777-2127

North Dakota State University Counseling and Disability Services (701) 231-7671

University of Missouri-Kansas City Counseling Services (816) 235-1635

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